The commencement of voluntary assisted dying in NSW

(A report from Anglican Community Services.)

Purpose

1. The purpose of this report is to advise Synod about Anglicare Sydney's adopted strategy of minimum compliance with the *Voluntary Assisted Dying Act 2022 (NSW)* and its ongoing provision of life-affirming services to residents in its homes in opposition to Voluntary Assisted Dying.

Recommendations

2. Synod receive this report.

3. Synod consider the following motion to be moved at the forthcoming session of Synod 'by the request of Standing Committee' –

> 'Synod, noting the report "The commencement of voluntary assisted dying in NSW" –
>
> (a) gives praise and thanks to God for his continued goodness in the provision of care and support to older persons living in residential aged care homes by Anglican Community Services (**Anglicare Sydney**),
>
> (b) thanks the members of the Archbishop's Working Group on Voluntary Assisted Dying and recommends the Working Group's Report to all who consider the passage of the *Voluntary Assisted Dying Act 2022 (NSW)* (**Act**) to be a tragedy for our society and a profound challenge for the church,
>
> (c) commends the decision by Anglicare Sydney to continue providing aged care services whilst adopting an approach that refuses to actively support euthanasia but complies with the Act, regulations and guidelines,
>
> (d) prays for the care and protection of all residents, their families and friends, and the staff, executives, and Board of Anglicare Sydney, as access to voluntary assisted dying becomes available on 28 November 2023 and beyond, and
>
> (e) reaffirms its opposition to voluntary assisted dying and calls on the NSW Parliament to repeal the Act, and failing that to administer the Act in such a manner as to permit faith-based organisations, including residential aged care providers, who oppose euthanasia on the grounds of institutional conscientious objection, not to participate in, facilitate or permit voluntary assisted dying in or at their premises, facilities or services in any way.'

Introduction

4. On 28 November 2023, eligible people will be able to choose to access euthanasia in NSW as set out in the *Voluntary Assisted Dying Act 2022 (NSW)* (**Act**), regulations and guidelines[1]. This is despite repeated, ultimately unsuccessful, calls for the Act to be either repealed or amended or for regulatory relief to be given on the grounds of conscientious objection, including by Synod, the Sydney Diocese, Anglican Community Services (**Anglicare Sydney**) and others.

5. As an operator, Anglicare Sydney will be required to allow voluntary assisted dying (**VAD**) in Anglicare Sydney's residential aged care homes from that time. This obligation creates significant theological and practical issues.

6. Anglicare faced a difficult choice to either comply with the Act or withdraw from providing care and support to older persons in its residential aged care homes. In response, the Archbishop established a *Working Group on Voluntary Assisted Dying* to consider the theological and practical issues and

[1] NSW Health has not issued the regulations or guidelines as at the date of this report.

to make recommendations to the Board of Anglicare Sydney and the Archbishop as President of Anglicare Sydney.

7. Anglicare's adopted position is that VAD will NOT be available at its residential aged care homes insofar as the Act allows. Policies and procedures have been developed to ensure this position is clearly communicated to all whilst ensuring strict compliance with Anglicare Sydney's obligations under the Act.

8. This report informs Synod about Anglicare Sydney's adopted strategy of minimum compliance with the Act and its ongoing provision of life-affirming services to residents in its homes in opposition to VAD.

Archbishop's Working Group on Voluntary Assisted Dying

9. The *Report of the Archbishop's Working Group on Voluntary Assisted Dying* (the **Report**, at Attachment 1) makes recommendations on the theological and practical issues confronting Anglicare Sydney to the Board of Anglicare Sydney and the Archbishop as President of Anglicare Sydney. The Archbishop established the Working Group in 2022, and Synod and others were invited to comment on the theological issues and implications of VAD.

10. The Report clearly sets out the biblical, theological and ethical "...considerations (that) have led Christians to consistently oppose the practices of physician-assisted suicide and euthanasia in the strongest terms, as essentially varieties of murder." The risks VAD represents to caring for the vulnerable, as commanded, is also considered. Finally, the Report discusses discerning between obeying God and honouring His established authorities.

11. The two pressing issues considered in detail were, one, would Anglicare Sydney be complicit if it complied with the Act, and two, does VAD intolerably corrupt the provision of residential aged care?

12. The Working Group concluded that Anglicare Sydney would not be complicit because the Act made VAD legal and provided that Anglicare Sydney made its opposition and non-active participation clear. As is discussed in the Report, the practice of VAD may eventually lead to a degree of corruption such that Anglicare Sydney would need to exit providing residential aged care, but this is not yet the case. Therefore, the recommendations are that Anglicare Sydney carefully monitors and evaluates the impact of VAD once it commences, develops policies and procedures that make clear its opposition and refusal to provide active support and continues, with others, to seek the overturning of the Act. Finally, the Report challenges Anglicare Sydney to respectfully, in compliance with the law, seek to dissuade residents from accessing VAD by "deed and word".

13. The Board of Anglicare Sydney commends the Report to Synod and all who agree that the passage of the Act and similar legislation is "a tragedy for our country and a profound challenge for the church".

How Anglicare Sydney is responding

14. As an operator, Anglicare Sydney will be required to allow euthanasia to occur in its residential aged care homes from 28 November 2023. Critically, under Sections 90-97 of the Act, residential aged care facilities must not hinder access to information, people providing information, a medical practitioner making assessments, and a person delivering, witnessing or administering VAD drug(s).

15. Having considered the Report and the ethical, practical and financial implications of alternatively exiting residential aged care, the Board of Anglicare Sydney decided insofar as the Act allows, VAD will NOT be available at its residential aged care homes, and the organisation and all staff will NOT actively participate in the provision of any VAD services. Policies and procedures have been developed to ensure this position is clearly communicated to staff, residents and prospective residents while ensuring Anglicare Sydney strictly complies with its obligations under the Act, regulations and guidelines.

16. To ensure compliance, Resident /Service agreements and contracts are being updated to confirm that Anglicare does not provide direct VAD services and stipulates that Anglicare staff will not be associated with such activities. Further, the updated agreements and contracts will clarify that the decision, assessment, and enabling act in VAD is a discussion and decision between the resident and their medical practitioner. The changes to agreements and contracts will be communicated to residents well in advance of the commencement of VAD on 28 November 2023.

17. All Anglicare Sydney staff working in its residential aged care homes will not initiate discussions, provide information or take any active part in a resident's VAD process, including subsequent steps. These prohibitions are permitted under the recognition of staff's right to conscientious objection and by the prohibition on caregivers initiating VAD discussions in Division 4 of the Act.

18. Anglicare Sydney is committed to the alternative, the excellent delivery of exceptional end-of-life palliative care services, holistically supporting a person's physical, emotional, and spiritual well-being through to the last stage of life and post-death. Anglicare Sydney will offer and support life-affirming choices for residents and provide chaplaincy support to residents and their family/friends, respecting their right to choose, thereby supporting them with maintaining their dignity through respecting their choice if and when a VAD decision has been made.

19. A VAD Readiness Steering Committee of senior executives has been established, reporting regularly to the Board's Care and Clinical Governance Committee and the Anglicare Sydney Board.

What's Next?

20. As NSW Health continues to disclose details of its full implementation of the Act, Anglicare Sydney is monitoring and, if required, updating its policies and procedures. Anglicare Sydney provides training and support to all staff on the Act and Anglicare Sydney's policies and procedures, supporting the adopted life-affirming position towards VAD. Anglicare Sydney is consulting with other Christian-based organisations in Victoria, Western Australia and Queensland that have successfully continued providing life-affirming care for older persons in a regime where euthanasia is permitted.

21. The Anglicare Sydney Board, with the senior executive team, will continually review the impact of VAD on the care and services it provides, including after the Act commences on 28 November 2023.

For and on behalf of the Board.

GREG HAMMOND OAM
Chairman, Anglican Community Services

17 July 2023

Attachment 1

Report of the Archbishop's Working Group on Voluntary Assisted Dying

Executive Summary

- The NSW Parliament passed The *Voluntary Assisted Dying Act 2022* (NSW) (**Act**) on the 19 May 2022. Its provisions automatically commence 18 months after the date of royal assent.
- The theological and practical issues Anglican Community Services (**Anglicare**) faces in grappling with a way forward in response to the Act, and the requirement to allow voluntary assisted dying to occur in Anglicare's residential aged care homes, are significant.
- In this report the Working Group provides some theological and practical reflections, and consequent guidance to the Board of Anglicare, and to the Archbishop as President of Anglicare.
- The Working Group has explored questions raised in its Terms of Reference and has concluded that –
    1. Despite still having to allow access by third parties who will provide voluntary assisted dying services, it is permissible (albeit not desired nor ideal), under certain circumstances and following additional operational considerations, to continue to provide Residential Aged Care.
    2. Anglicare will need to undertake a significant work (including that specified within this report) in preparation for the implementation of VAD in November 2023.
    3. Anglicare should commit to a watching brief and regular reporting to the Executive and Board on this novel unwanted practice. Such reporting should at least include,
        (a) the impact of VAD within Anglicare facilities, (especially the utilisation and operations of VAD),
        (b) the impact of VAD on other residents and the community of the Home, and
        (c) the impact of VAD on the staff and volunteers within the Home.
    4. Consideration should be given to collecting this information as a formal research project.
    5. Anglicare should commit to a formal review of VAD within its Homes. This should be presented to the Board no later than 2 years from the commencement date of the Act.
    6. If Anglicare continues in Residential Aged Care at this time, it should be recognised that the existence of VAD may well become an intolerable corruption to the service, thus precipitating the need for withdrawal from Residential Aged Care provision in the future.
- Although this Act may well have implication for other operations within Anglicare, particularly Independent Seniors Living and Anglicare at Home services, the Working Group decided to focus its attention on the Residential Aged Care context as that most impacted by the legislation. We do, however, note that the theological reflections and moral reasoning articulated here are relevant for Anglicare's internal consideration of the implication of this Act on those operations.

A/Professor Megan Best
The Rev Dr Andrew Errington
The Rev Dr Andrew Ford (Chair)
Mr David Goodhew
The Rev Dr Chase Kuhn
Professor Jonathan Morris
The Rt Rev Dr Michael Stead

2 December 2022

Introduction

The passing of the *Voluntary Assisted Dying Act 2022 (NSW)* (the Act) has significant practical and ethical implications for Anglicare, and requires considered reflection. This report aims to respond to the Terms of Reference given to the Archbishop's Working Group (Appendix A), and to move towards clarifying both the questions that need further investigation and some of the practical issues that need attention over the coming months as the details of the implementation of the legislation become clearer. It is anticipated that some questions will not be fully resolved until further information about the implementation of the Act is forthcoming from NSW Health.

The 3rd Session, 52nd Synod passed resolution 5/22 in relation to Voluntary Assisted Dying (VAD). Amongst other things it extended an invitation for comments from members of Synod on the theological issues and implications of VAD. No comments were received.

§1 Biblical and theological principles[1] (Terms of Reference (a))

The message of the gospel is a message of freedom from the fear of death. All human beings face death: 'It is appointed for mortals to die once, and after that the judgment' (Heb. 9:27). Death, furthermore, is a prospect that is fundamentally out of our control. For we are only creatures, but death and life are in the hand of the Creator.

> 'See now', says the Lord:
> … that I myself am he!
> There is no god besides me.
> I put to death and I bring to life,
> I have wounded and I will heal,
> and no one can deliver out of my hand. (Deut. 32:39)

As the psalmist sees, we stand alongside all creatures in utter dependence upon our Creator:

> All creatures look to you
> to give them their food at the proper time.
> When you give it to them,
> they gather it up;
> when you open your hand,
> they are satisfied with good things.
> When you hide your face,
> they are terrified;
> when you take away their breath,
> they die and return to the dust.
> When you send your Spirit,
> they are created,
> and you renew the face of the ground. (Psalm 104:27–30)

Death is a humbling reality, reminding us that we are only creatures and not the Creator.

Yet, for human beings, death is not merely humbling but also threatening and fearful, because we face it not merely as creatures, whose lives have a natural span and finitude, but as sinners. 'The sting of death', writes the apostle Paul, 'is sin' (1 Cor. 15:56). We face death, therefore, as a gateway to ultimate loss, as those who have failed to live as we were made to and so stand condemned and under the wrath of God.

However, as the book of Hebrews tells us, the Lord Jesus Christ, the Son of God, shared our human nature and condition, 'so that by his death he might break the power of him who holds the power of death – that is, the devil – and free those who all their lives were held in slavery by the fear of death' (Heb. 2:14–15).

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[1] For a more detailed discussion of some of these points, see Rev Dr Andrew Errington, 'Against "Voluntary Assisted Dying"', https://ccl.moore.edu.au/resources/against-voluntary-assisted-dying-andrew-errington/; Bishop Michael Stead, 'Why We Must Oppose Assisted Suicide,' https://sydneyanglicans.net/news/why-we-must-oppose-assisted-suicide/51678; Rev Dr Chase Kuhn, 'Euthanasia and a Different Sort of Compassion,' https://sydneyanglicans.net/news/euthanasia-and-a-different-sort-of-compassion/51587; Dr Megan Best, 'Palliative Care and the Art of Dying Well,' https://au.thegospelcoalition.org/article/palliative-care-and-the-art-of-dying-well/

'Do not be afraid!' declares the risen Lord, 'I am the First and the Last. I am the Living One: I was dead, and now look, I am alive forever and ever! And I hold the keys of Death and Hades' (Rev. 1.17–18). 'Thanks be to God! He gives us the victory through our Lord Jesus Christ' (1 Cor. 15:57).

Christ's conquest of death brings the freedom to face death without fear, to submit to it and to face it with confidence and hope, as a final trial through which we must pass, and beyond which lies glory. It allows us to accept and even to welcome death when it comes, because of that to which it leads us (Phil. 1:23), in hope of the day when Death will be 'swallowed up in victory' (1 Cor. 15:54) through resurrection.

As a correlate of this understanding of death, the fear of death, and the gospel's promise of freedom and life in Christ, the Christian tradition understands suicide and assisted suicide as forbidden by the sixth commandment, 'You shall not murder' (Exod 20:13; Deut 5:17). Although this commandment does not prohibit every form of killing – in the Old Testament and throughout much of Christian tradition, some killing in war and in judicial punishment has been seen as lawful – it is a clear prohibition of private killing. This commandment recognises that the deliberate taking of human life is a special boundary that must be carefully safeguarded because human beings are created in God's image (Gen. 1.27; 9.6). Stories of suicides and assisted suicides in the Bible therefore all reflect a clear sense of shame and failure (see Judg 9:52–4; Judg 16:28; 1 Sam 31:1–6; 1 Chr 10:1–6; 2 Sam 17:23; 1 Kings 16:18; Matt 27:3–5).

In the light of this Biblical witness, the Christian tradition has mostly maintained that suicide is unlawful, a forbidden breach of the commandment not to kill, a kind of 'self-murder'. Augustine's judgment represents the mainstream of the tradition: 'if no one has a private right to kill even a guilty man … then certainly anyone who kills himself is a murderer'.[2]

At stake is the fundamental conviction that it is the prerogative of God to take human life. The practices of suicide, assisted suicide, and euthanasia represent a temptation to take the bounds of human life into our own hands that must be resisted, even though various practices of modern medicine can make it appear that such resistance is no longer meaningful – practices such as screening embryos, and prolonging life through artificial support. The Bible's understanding of suffering and endurance depends on the acceptance of limits to the legitimate scope of our control of our own life.

The pastoral realities of suicide are, of course, deeply complex, and painful. Yet pastoral practice is assisted, rather than impeded, by clarity on this foundational principle, even if there are many further issues to discuss, most especially including the challenges of mental ill-health. And the principle is of great importance when it comes to issues of public law and institutional practice.

These considerations have led Christians to consistently oppose the practices of physician-assisted suicide and euthanasia in the strongest terms, as essentially varieties of murder. In addition, these practices raise grave public-policy concerns, especially relating to the care of the vulnerable. The difficulties involved in adequately safeguarding these practices, ensuring transparency, protecting against the corruption of medicine, and the risks they pose to people affected by various kinds of disabilities, are well-documented.[3] The example of Christ's care for the weakest and most invisible, and the biblical exhortation to give special attention to the weak and the needy (e.g. Matt. 25:31–46), give these considerations a special weight.

Although some have argued in recent years that euthanasia and physician assisted suicide are in fact permissible for Christians,[4] these arguments have not been widely regarded as persuasive. In general, the Christian church remains widely opposed to physician-assisted suicide and euthanasia, which are the practices involved, respectively, in self-administered and practitioner-administered 'voluntary assisted dying' (the euphemistic terminology adopted in the Act). The Diocese of Sydney has consistently opposed the legalisation of these practices on grounds of principled opposition and good public policy.[5]

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2 Augustine, *City of God* I.17 (trans. H. Bettenson; Penguin, 1984), p. 27.

3 See for example, David Albert Jones, Chris Gastmans, and Calum MacKellar, eds., *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press, 2017). For a summary of the public policy issues, see Andrew Errington, 'Against "Voluntary Assisted Dying"'; and Megan Best, "Assisted Dying Laws: Is suffering still the main problem?" https://www.case.edu.au/blogs/case-subscription-library/assisted-dying-laws-is-suffering-still-the-main-problem

4 See, most notable, Paul Badham, *Is there a Christian Case for Assisted Dying: Voluntary Euthanasia Reassessed* (London: SPCK, 2009); and Jonathan Romain and George Carey, 'There is nothing holy about agony: religious people and leaders support assisted dying too', *BMJ* 374.2094 (2021): https://www.bmj.com/content/374/bmj.n2094.

5 As recently expressed in its submission to the NSW Parliaments, Standing Committee on Law and Justice, *Provisions of the Voluntary Assisted Dying Bill 2021*- Submission No 42.

Christians are called to honour human institutions and to submit to governing authorities (Rom. 13:1–7; 1 Pet. 2:13–17), for the fundamental task of political authority to secure a limited space of peace and freedom is of service to the mission of the gospel (1 Tim. 2:1–4). Holy Scripture also testifies, however, that political authority can exceed this task. The kings of the earth can 'band together' against the Lord and his Messiah (Psalm 2:2; Acts 4:25–26). When this happens there may be moments when Christians must refuse to obey what is asked of them, though even this may often be done with a spirit of respect for authority (Acts 4:18–22; 5:27–32).

When laws are made, therefore, that Christians know to be unjust, we are faced with a complex task of discerning how we may obey God and still honour the authorities God has established (Rom. 13:1). Sometimes this may mean the gracious acceptance of the consequences of the disobedience, as we see with the apostles in the book of Acts (Acts 4:19). At other times it may mean withdrawing from forms of public service that we are no longer able, in good conscience, to undertake. In the context of modern Australia, it often entails negotiation with government to find a pathway to forms of action that are mutually acceptable.

§2 Ethical questions raised by the Act (Terms of Reference (b))

These considerations must make us regard the passing of the NSW Act, and of the similar Acts passed over the last few years in other Australian jurisdictions, as a tragedy for our society and a profound challenge for the church. What must now be considered is what practical, pastoral and theological responses this legislation calls for. Although it is not the task of the working group to consider these responses in all their breadth, it is worth noting that the practice of VAD within our society will raise many pastoral challenges. The change of law puts into the hands of an individual a decision with the gravest moral significance, and this will have serious impacts upon the life and practice of our churches. Christians will face decisions for themselves and their loved ones. Families maybe painfully divided. Churches and church leaders will need to consider questions of church discipline.

Turning now to the impact of the legislation on Anglicare, the first thing to recognise is the complexity and uncertainty of the issues facing Anglicare.

a) Complexity

The complexity of the issues facing Anglicare is a product of both the distinctiveness of the Residential Aged Care setting and the legislation itself. Anglicare has a long history of caring for the frail elderly within our society, including through the last phases of life until death. Although this care can and does happen in people's private homes, the primary sphere upon which this legislation will have an immediate impact is Residential Aged Care. This is not only because this is a specific focus of the legislation, but also because it is where Anglicare has some control and influence with respect to the physical site, and some direction and responsibility for the provision of care services provided to residents in these sites. This stands alongside the reality both in regulation and expectation that such an Anglicare site has become for the resident their home. Both these realities – that the location in view is both a property controlled by Anglicare and an individual person's home – shape the legislation and create complexities in considering possible responses to it[6].

The provision of medical services in Residential Aged Care is also complex. Primary health care services in facilities run by Anglicare are not simply a service provided by Anglicare to the resident, but rather a provision of service requested and authorised by external health care professionals. Anglicare does not employ physicians (General Practitioners, Geriatricians etc). Rather, residents (or their Person Responsible) maintain a 'private' arrangement (albeit sometimes facilitated by Anglicare), with primary external health care professionals of their choosing. It is these health practitioners who prescribe treatments for residents in Anglicare Homes. In normal operational circumstances suitably qualified Anglicare staff (e.g. Registered Nurses and the like) do undertake procedures and administer medications as prescribed by these physicians. In this portion of the administration of health care Anglicare has manifest control.

Regarding the legislation itself, positively, the Act clearly makes room for a residential facility to refuse 'to provide services relating to voluntary assisted dying at the facility….' [§89.1]. It further specifies that this includes refusing to 'participate in the request and assessment process'; 'participate in an administrative

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[6] We note that Anglicare is commitment of to ensure that 'facilities' are the resident's 'home'. Amongst other things this happens through, ensuring an excellent standard of care, facilitating of real community, and building a culture of belonging. As such Anglicare always refers to it residential aged care facilities as "Homes".

decision'; 'prescribe, supply, or administer a VAD substance'; 'store a VAD substance'; or 'be present at the time of administration or self-administration' [§89.2]. On the face of the legislation, therefore, Anglicare will apparently be free to not actively engage in the direct delivery of VAD services.

It is worth registering a caution at this point, however. This issue of storage is complex. For if residential facilities are free to refuse to store VAD substances, what will happen to them? There are clear potential conflicts between the legislative obligations residential facilities have relating to the storage of dangerous drugs and the freedom to refuse to store a VAD substance. This issue awaits clarification, hopefully in regulations to come prior to the commencement of VAD.[7] This issue is not insignificant, because it may represent a moral step into a position of tacit, active support for VAD. This issue is explored below.

What the Act does require of residential facilities is, first, that they 'not hinder' a person's 'access at the residential facility to information about voluntary assisted dying' [§90.2]. This 'not hindering', however, does not appear to mean the active provision of information, because the following point requires the facility to provide access to a person who can provide the relevant information [§90.2]. The only information a residential facility must provide appears to be information about the fact that the facility does not provide VAD services. This information must be provided in an effective way [§98]. Secondly, the Act requires that the facility permit access to VAD services through VAD practitioners [§§91–97], which extends to permitting access for an external health practitioner to administer a VAD substance or to deliver a VAD substance for purposes of self-administration.

The requirements of the Act that residential facilities allow access to information about voluntary assisted dying and to the provision of these services in their facilities raises instinctive ethical concerns. It is useful to begin by clarifying two different kinds of concern.

b) Complicity

The first is the concern raised in the Terms of Reference for the working group that this requirement might make Anglicare 'complicit in the delivery of the services in a way which would be contrary to the teaching of the Bible'. Complicity is primarily a legal category, with highly specific qualifications. It is worth clarifying that there is no prospect of Anglicare being legally complicit because the action in question is no longer a crime. However, the term is also used in broader moral terms to describe the way a moral agent may be 'objectionably involved' in an immoral act without their being directly responsible for it.[8] This may happen in a range of ways. Most straightforwardly – and this is the primary way complicity functions at a legal level – an agent can be complicit in an act if the act is done with their assistance or encouragement. If I say to someone, 'Go on, shoot him', and he does, then I am complicit in the shooting. However, moral complicity also seems to extend to wider forms of involvement. An agent might also be felt to be complicit through a failure to take action to prevent the evil act occurring that the agent might reasonably have taken. If I know that a robbery is about to take place and fail to alert the police, I might be felt to be morally complicit in some wider sense. Here, however, things get complicated. In this situation, the obligation that, say, a frightened spouse of the robber must alert the police is different to the obligation someone in a position of power and security would have. One person's silence might be judged objectionable when the other's might not because of further considerations.

Someone might also be considered to be complicit in some sense if they facilitated an evil act. If, despite the fact that I know my flatmate is an alcoholic, I leave bottles of wine around the house in obvious places, I might be considered to be complicit in his ongoing addiction. If a rector or school principal allowed a known paedophile to occupy a role looking after children, they might be considered complicit in any subsequent abuse. In certain conditions, each of these examples could be considered instances of wilful negligence; but complicity might be felt to be the right term if these risks were undertaken with a clear awareness of the likely consequences. An organisation might be regarded as complicit if they knowingly allowed their premises to be used for human trafficking – this is clearly a form of morally objectionable involvement in the action.

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7 Under the Act the VAD substance will be a Schedule 4 or Schedule 8 poison [§7.1]. These drugs have a variety of medical uses and are highly regulated. In normal operations they are securely stored by Anglicare. Upon prescription by a primary health care provider, these drugs would only be dispensed and administered by authorized Anglicare personnel. We note that §79 of the Act, which concerns the storage of VAD substances, appears to be in conflict with the regular practice in a residential aged care facility. However, §14 reads, "**Relationship with *Poisons and Therapeutic Goods Act 1966* and *Drug Misuse and Trafficking Act 1985*:** If there is an inconsistency between a provision of this Act and a provision of the *Poisons and Therapeutic Goods Act 1966* or the *Drug Misuse and Trafficking Act 1985*, the provision of this Act prevails to the extent of the conflict or inconsistency."

8 The phrase is taken from Neal Tognazzini and D. Justin Coates, 'Blame', *Stanford Encyclopedia of Philosophy*: https://plato.stanford.edu/entries/blame/#MorAge

This final example draws us closer to the issue facing Anglicare. Does the legal requirement to allow access to VAD information and services by external parties put Anglicare in a position of complicity in this way? Notice, however, two important differences from the example. First, the choice to allow access does not belong to Anglicare but has been taken out of its hands by the legislation. The only choice Anglicare has is whether to operate residential aged care facilities given this requirement. And even this is not a simple choice, because for a range of reasons, including existing commitments to residents and financial concerns, such a step could not reasonably be taken prior to the legislation coming into force.

The second difference is that the morally objectionable actions in question now have a different legal status. Human trafficking is a criminal act, but the provision of VAD services is not. This significantly complicates the issue of complicity because it alters the public context of the act, and the expectations the organisation may have of other agents. In a previous generation, a hotelier might have been felt to be complicit in sexual immorality if she permitted unmarried guests to share a bedroom. It would be hard to maintain the same judgment now. The reason is that the public context has changed. The hotelier can no longer count on widespread social support for her action, and the accompanying sense of shame for the people involved. This means that her permission no longer represents an active enabling of sexual immorality, and the refusal of permission might involve costs to her that are no longer reasonable to expect in such a public context.

Returning, then, to Anglicare, there are reasons to suspect that the legislative requirement to allow access to euthanasia services will not put Anglicare in a position of complicity in relation to the delivery of VAD. Anglicare will apparently be in a position where it is required only to signal that it does not provide VAD services, to allow others to provide information to residents 'if asked' [§90.2. b], and to allow others to enter its facility in order to engage with residents on this issue, make decisions and administer VAD substances. Were Anglicare free to refuse access to information and VAD, the decision not to do so would arguably put Anglicare in a position of complicity; but this is not the situation Anglicare is in. There is no sense in which Anglicare would be actively enabling euthanasia and physician-assisted suicide. As long as Anglicare is free to make clear that it does not provide VAD information and services and does not support them other than as required by the legislation, it is hard to see how this involvement could be considered a form of complicity.

That said, it is worth recognising that the complexity of this argument means that there may well be people, including concerned parties such as Anglicare staff and residents, who will continue to think that for Anglicare to permit VAD on its premises does constitute a form of objectionable involvement. The moral significance of such felt convictions must be respected and may play a role in creating a situation in which the ongoing provision of residential aged care by Anglicare becomes extremely difficult. This leads us to a second kind of ethical concern.

c) Intolerable corruption

The concern about complicity is not the only kind of concern raised by the Act. A second concern is that this development constitutes what we might call an intolerable corruption of the practice of providing residential aged care in Australia. As noted above, the decision over which Anglicare does have some choice is the decision to continue to operate residential aged care facilities. Its commitments to existing residents notwithstanding, Anglicare does have the freedom to cease providing this care over time. It might, therefore, be argued that the requirement to allow access to information about and services relating to VAD so corrupts the practice of providing residential aged care that Anglicare ought to make use of this freedom. Recalling for the sake of analogy the example noted above, a Christian hotelier might decide that the changed public expectations about sex and marriage had so poisoned the work of operating a hotel that it was no longer a good thing to do.

There are a number of things to say about this suggestion. The first is that this is a question that will have to be discerned over time. The extent to which the practice of VAD will corrupt the work of providing aged care is not yet clear. It will depend upon the details of implementation, which are not yet available, and upon the lived reality of putting them to work in different contexts. In any case, Anglicare could not cease operating aged care facilities quickly. This, therefore, should be seen as a question to revisit and/or pay attention to over time.

Secondly, we should beware of adopting an implicit logic of pollution, according to which the mere proximity to certain kinds of evil acts is felt to be intolerable. Although this logic is easily adopted, it is not deeply Christian. The Christian life is not lived according to a logic of clean and unclean, because it is not from outside, but from within, that one is defiled (Mark 7:1–23). Christ does not ask the Father to take his disciples 'out of the world', but to protect them from the evil one and to sanctify them while they journey within it (John 17:15–17). The truth is that no church, home, community, or aged care facility is free of evil;

we should beware of assuming that the presence of this imposed evil, which has special public prominence, is uniquely corrupting.

Thirdly, that said, it should be acknowledged that the requirements noted, despite their minimal nature, may pose real risks to the practice of providing aged care. The presence of VAD discussions and practitioners may have a range of impacts upon the culture and experience of residential facilities. It may distort perceptions of Anglicare staff, or damage residents' sense of the safety of their home. It may complicate and add stress to the role of the facility manager, as the one who has to navigate the provision of access and information, which may in turn hinder the ability of Anglicare to find suitable staff for this already stressful role. It may also have profoundly difficult impacts upon the practice of pastoral care for the dying. Chaplains and other staff providing pastoral care will face extremely challenging decisions about how to care for those ending their life by euthanasia or assisted suicide. Such situations can be conducive of forms of moral injury, and Anglicare will need to invest significant energy and time in the creation of policies and procedures for such situations. Additional challenges for Anglicare are easy to envisage, such as responding to the event of a malfunction in the administration of a VAD substance, an issue known to cause acute stress in emergency departments. These are some of the matters that will need to be thought through, and watched, as time proceeds and further details emerge. This leads us to the courses of action open to Anglicare at this juncture.

§3 Courses of action to be considered by Anglicare (Terms of Reference (c), (d), and (e))

Anglicare has had a longstanding public opposition to euthanasia. This was most recently expressed in its submission to NSW Parliament's Standing Committee on Law and Justice, Provisions of the Voluntary Assisted Dying Bill 2021- Submission No 55, in which Anglicare outlined its desires and intentions with respect to the provision of care. A summary of these commitments is contained in Appendix B.

From the date of commencement, some residents may well commit suicide through the provision available in this Act while residing in Anglicare's Homes. Considering what has been discussed, if Anglicare is to continue to provide residential aged care, it will need to undertake a significant body of work to ensure that it can both provide the kind of life-affirming care it desires to give to residents in its facilities, up to and including the end of life.

Given that the practice of VAD is antithetical to Anglicare's ethos of care, and moreover will potentially undermine the practical outworking of that ethos, Anglicare will need, at a minimum, to make significant efforts, invest appropriate resources, and potentially significantly transform its current operations to ensure that the desires and commitments expressed in its submission (see Appendix B) are not only aspirational but are clearly and consistently a reality in each of its residential aged care facilities.

It should be noted, however, that a decision to withdraw from providing residential aged care cannot be ruled out at this point. To be sure, such a decision should not – and indeed could not – be taken lightly. It would come at the significant cost of forgoing all the good Anglicare does both in terms of care, the provision of Christian ministry and the evangelistic fruit that is abundant in our residential aged care homes. It would also be extraordinarily costly and difficult.[9] However, such a course of action cannot be categorically ruled out, as there remain, as discussed above, significant unanswered questions and ambiguities that could result, perhaps quickly or perhaps over a longer period, in Anglicare's ongoing provision of residential aged care becoming untenable.

Bearing all this in mind, at this stage we believe that Anglicare should consider the following courses of action.

a) Build upon existing commitments to palliative care

The single most important response Anglicare must take is to continue and to build upon its existing commitment to palliative care. This includes commitment to ongoing active service improvement, and investment in skilled and experienced palliative care practitioners. Anglicare should ensure that its aspirations for excellent palliative care are consistently met in all its residential aged care homes. This will

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9 The financial liabilities involved in a rapid exit from Residential Aged Care would deprive Anglicare of the ability to provide the vast majority of their other benevolent community services, such as Food and Financial services and Chaplaincy.

act as a preventative measure against VAD and ensure that opposition to VAD can be voiced and sustained with integrity.

b) Advocate for Legislative reform and Regulative clarity

Anglicare alongside the Diocese should continue to call on the NSW Government to remove the obligation of all residential aged care providers to allow VAD on their premises, and to provide adequate and timely access to palliative care for all NSW citizens. Anglicare should also proactively engage with those developing Regulations under the Act and other implementation guidelines, to ensure that the concerns identified in this paper (such as inconsistencies around storage of VAD substances) are clarified.

c) Review and monitor developments

Anglicare should develop a plan for reviewing and monitoring the implementation of the legislation and its ongoing impacts. The roll-out of the legislation needs to be watched with care, and then significant impacts will need to be tracked. It will be important that Anglicare, as far as it is able, is aware of whether and how many requests to access VAD are made within its homes, how these requests are responded to, the outcome of such requests (in terms of pursuing VAD or non-completion of the VAD pathway) and assessment of the impact of the process upon staff and other residents.

Anglicare could consider advocating for and resourcing research on these matters and consider addressing the quality control measures above as a research project, the result of which could be published as an academic journal article, therefore raising relevant issues for academic and community debate. In the planning and implementation of such research, care would need to be taken to ensure any such research would not impinge on either the provision of quality care, the culture and environment of the Home, or unnecessarily impact on the commercial setting of the Home. Care would also need to be taken to ensure such research was not at cross purposes with other responses Anglicare will need to make in response to the Act (e.g. it's stance towards communication concerning VAD). Issues of staff and patient confidentiality should be addressed by a standard research protocol. Approval of the protocol by a Human Research Ethics Committee would be required if the research was to be published in an academic journal. It should be noted that the ethical approval for such a process would ideally need to be in place prior to the implementation of the Act.

Once the implementation regulations have been produced, and prior to the commencement of the Act, Anglicare should conduct an internal policy and procedure review. This assessment should give special attention to the facility manager and their particular responsibilities arising under the Act and its provisions.

Anglicare should also commit to a formal review of VAD within its residential aged care facilities once VAD has been established but well before any normalisation of the process makes such an assessment difficult. A report on such should be presented to the Board no later than 2 years from the commencement of the Act. In due time a legal risk assessment of the Act and any proposed operational responses will also be required.

d) Development of policies and procedures

Anglicare should immediately begin to develop policies and procedures to enable the organisation to meet the various challenges posed by the legislation. At least the following warrant attention:

- Policies and procedures for all staff concerning the organisational position of non-participation in VAD. This should form part of Anglicare's Code of Conduct.
- A communication strategy that would fulfil the Act's requirements for provision of information concerning VAD. The Working Group discussed whether this could be done in pre-admission information given to prospective residents, and then the same reissued on the allocation of a bed. Such communications could be within an information flyer detailing Anglicare's life affirming care service offering, including Palliative care. The information on VAD could come with a note about the organisation's in-principle opposition, and non-provision of these services, but then pointing people (as required by law) to information in the form of a link to an appropriate NSW Health website (e.g. https://www.health.nsw.gov.au/voluntary-assisted-dying). When a resident asks for information concerning VAD, they could be directed back to the already provided information. Note that legal review of these procedures would be required to ensure that they do not contravene the provisions in the Act regarding raising the topic of VAD with residents.

- Policies and procedures that ensure the safety of all in the Home, and the provision of life-affirming care for all residents especially as this risk profile changes with the introduction of VAD. Things to be considered include:
    - security of VAD substances and ensuring non-accessibility without the need for Anglicare staff to be involved in the storage of such;
    - active monitoring process implemented designed to detect coercive practices with respect to others encouraging a resident to undertake VAD;
    - ensuring life-enriching care; cultivating caring compassionate communities that honour life and appropriately grieve death.
    - ensuring that Anglicare facilities are not used for gatherings to "celebrate" the termination of life, such as a "pre-wake".
- Procedures should be developed for misadventure or malfunction in the administration and effect of the VAD substance. Life-affirming care should be the default position here, however this would also need to consider any Advanced Directive in place. A standard policy should be in place for when transfer to hospital is required for specialised medical attention.
- Policies and procedures relating to the desirability and use of Advance Directives.
- Practical guidance and appropriate ministry tools (rites, rituals etc) should be developed for Pastoral Care and Chaplaincy personnel (staff and volunteers).
- Policies and procedures relating to the care and support of staff and residents who are connected to people dying by VAD. Anglicare should be aware of the risk of moral distress and take necessary steps to provide a safe working environment considering this risk.

e) Development of a pastoral strategy for responding to requests for VAD

Anglicare should carefully develop a pastoral strategy for responding to requests for VAD. It should be noted that a request for hastened death at the end of life is well known to be an expression of distress and not necessarily a desire to receive VAD. Therefore, when a resident expresses a request for hastened death, whether or not a specific reference to VAD is included, the appropriate response from Anglicare should include the following:

1. Explore the circumstances which have prompted this request and address any problems which are identified.
2. Ensure that pastoral care is involved in resident care.
3. Ensure that the resident is referred to high quality palliative care.
4. Respond respectfully and compassionately to residents' questions about VAD.
5. Assure residents that they will never be abandoned.

Under the Act Anglicare has no legal right to prevent permanent residents from independently accessing VAD services.[10] However, Anglicare may wish to dissuade residents from doing so by deed and by word.

Dissuasion respects the autonomy of an individual by regarding them as open to thoughtful reflection. Christians recognise respect for autonomy as due to all mentally competent human beings who are made in the image of God and as such are free to choose to access legally available procedures.[11] Respect does mean a willingness to accept that others may come to a judgement with which we do not agree, but it does not mean unquestioning reverence for every expressed desire. Respect, rather, can encompass a willingness to engage with a person and to give them space to come to a considered judgement, including putting before them reasons to consider a different course of action.

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[10] Moreover under the The Aged Care Quality Standards, which Anglicare must fulfil to remain an approved Aged Care provider, the first and core standard is, Standard 1: Consumer dignity and choice. The respect due to someone under this standard also extends even to an individual making choices and decisions that may even put themselves in harm's way. This is often referred to as 'dignity of risk'.

[11] That said, even apart from legislative restrictions, autonomy is never completely unfettered. In certain circumstances we can insist on the imposition and acceptance of restrictions in order say, for one to be a member of a particular association with others (like a church congregation) or insist on restrictions to continue to enjoy the use of or cohabitation in a 'privately' owned location. In a real sense in both these examples the individual chooses to set aside their freedom and be bound by another's choice. These avenues for restricting autonomy apart for the constraint of the law do not strictly or better still simply apply to Anglicare.

Reasons to dissuade someone from pursuing VAD

There are in fact numerous reasons why it might be right to seek to dissuade people from pursuing VAD. These include the following:

i) VAD legislation ignores research relevant to requests for hastened death

Research has found that when patients express their fears at the end of life, healthcare staff often misinterpret this fear as a request for euthanasia when it is really intended to be a cry for help.12 The appropriate response to a request for hastened death is therefore to ask what is wrong. Research shows that requests for euthanasia and physician assisted dying are usually due to undiagnosed depression, demoralisation, loneliness, fear of being a burden or lack of support.13 All these issues can be addressed with comprehensive care. Physical pain is an uncommon reason for a request of euthanasia and uncommon at the end of life when high quality palliative care is available. Patient desires are known to fluctuate over time, including desires for hastened death.14 That suggests that even if patients request euthanasia, they may have changed their mind if they had spent more time considering their decision.

ii) VAD legislation is misrepresented by government as healthcare

The government's assertion that prescription of a poison to a person to allow them or assist them to end their life is a form of healthcare is false.15 The goals of medicine and healthcare involve the preservation of life where possible and comfort care when cure it not possible, while neither hastening nor deferring death. VAD terminology seeks to provide a cloak of medical legitimacy to state sanctioned killing. Both the Australian Medical Association 16 and the World Medical Association 17 are opposed to medical practitioners being involved with euthanasia and physician-assisted suicide, even where they are legal.

Making VAD legal does not make VAD a valid "choice" to replace quality palliative care, although the legalisation of euthanasia and physician assisted suicide removes the imperative for governments to provide good end of life care. The rhetoric in our community about VAD as a "healthcare" choice and the use of euphemisms to mask the reality of the procedure make it important for Anglicare to ensure that residents have an opportunity to understand the evil nature of this project before engaging with pro-VAD personnel.

iii) This (and other) VAD legislation has inadequate safeguards to protect the vulnerable

Despite the efforts of Anglicare and many others to amend the legislation and see more robust safeguards legislated, we are left with an Act with inadequate safeguards. This obliges Anglicare be vigilant with what safeguards are there and to urge caution to residents considering VAD as part of its duty of care to a vulnerable group. Inherent risks in the Act include the following:

- Decision-making capacity of the patient is assumed [§6(2)(b)], a questionable assumption in a population with advanced disease. Cognitive capacity is known to be impacted negatively by factors such as organ failure, medical treatments, and psychological morbidity. Research shows that 35% of people with physical and mental illness may lack capacity to make decisions about their health.[18] There is no requirement for a psychiatric assessment in the legislation to determine whether the patient is mentally competent.

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12 Johansen S, Hølen JC, Kaasa S, Kaasa S, Loge JH, Materstvedt LJ. 'Attitudes towards, and wishes for, euthanasia in advanced cancer patients at a palliative medicine unit.' *Palliative Medicine.* 2005;19(6):454-60.

13 Hudson PL, Kristjanson LJ, Ashby M, Kelly B, Schofield P, Hudson R, *et al*. 'Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review.' *Palliative Medicine.* 2006; 20(7):693-701; Oregon Death with Dignity Act: 2020 Data Summary. Public Health Division, Center for Health Statistics. February 26, 2021.

14 Chochinov HM, Tataryn D, Clinch JJ, Dudgeon D. 'Will to live in the terminally ill.' *The Lancet*. 1999;354(9181):816-9.

15 Boudreau JD, Somerville MA. 'Euthanasia is not medical treatment.' *Br Med Bull*. 2013 106:45-66.

16 AMA Position Statement. Euthanasia and Physician Assisted Suicide. AMA 2016. file:///Users/megan_best/Downloads/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016-1.pdf

17 WMA Declaration on Euthanasia and Physician-Assisted Suicide. 2019. https://www.wma.net/policies-post/wma-resolution-on-euthanasia/

18 Breitbart, W. 'Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer.' *Journal of the American Medical Association* (Dec. 13, 2000); Lepping, P, *et al*. 'Systematic Review on the prevalence of lack of capacity in medical and psychiatric settings.' *J Clin Med (Lond)* 2015; 15(4).

- The eligibility criteria include a prognosis of 6 months, or 12 months for a neurodegenerative condition [§16(1)(d)], but the standard of assessment is the balance of probabilities. There is extensive research showing that it is not possible to predict life expectancy with any accuracy,[19] and there is no requirement for VAD doctors to check the records of the patient's own treating doctors to ensure accuracy of medical information. Coordinating or consulting practitioners are not required to be specialists in the patient's illness or the patient's usual doctor [§18].
- Mental illness per se does not disqualify a person from euthanasia [§16(2)(b)]. With this legislation, as long as a person can understand the decision, mental illness (e.g., clinical depression) does not prevent a person from accessing euthanasia or assisted suicide. Treatment of depression in the palliative care setting is effective and we know that thoughts around suicide are not static and resolve when depression is treated.
- A person can make euthanasia requests using "gestures," but these are not specified or recorded [§19(3)(b), §48(3)(b), §57(3)(b)]. If unspecified "gestures" are enough to make a death request, it is the doctor's interpretation of the gestures that prevails.
- The eligibility criterion for suffering is assessed subjectively by the patient and they are not required to avail themselves of any means by which suffering may be relieved before accessing VAD if the means are not acceptable to them [§16(d)(iii)]. Evidence shows that the wish to hasten death reduces in patients who receive good palliative care.[20] However, this effect operates only when the patient *receives* the care, not when they are just told about it. In this legislation, the person informing the patient about palliative care options is not required to have any expertise in palliative care, and patients are not even required to have received a referral to palliative care, in order to find out the true extent of options available to them.
- This legislation anticipates problems with identifying coercion and undue influence, as referral to a psychiatrist or psychologist is suggested to assess pressure or duress [§27]. However, the fact that this is not mandated shows that this risk is underestimated. This is of particular concern as elder abuse has been identified as a pervasive problem in NSW by the Legislative Council's report on Elder Abuse released in 2016.[21] Similar issues were identified in the Australian Law Reform Commission's (ALRC) report on elder abuse released in 2017.[22] While the exact prevalence of elder abuse is not established in NSW, the ALRC reported that, at the international level, estimated prevalence rates of elder abuse range from 2-14% and may be as high at 20% in older women. Coercive control is regularly observed by healthcare professionals in the aged care setting, but it is difficult to detect.
- Time between first and final request can be as short as 5 days, or even shorter if the patient is expected to die or lose mental capacity within 5 days [§49]. Research has shown that the desire for hastened death often fluctuates over time.[23] This period between first requesting VAD and receiving it does not allow sufficient time for reflection and determining whether the request for hastened death is permanent.

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19 White, *op.cit.*

20 Breitbart W, Rosenfeld B, Gibson C, Pessin H, Poppito S, Nelson C, *et al.* 'Meaning-centered group psychotherapy for patients with advanced cancer: A pilot randomized controlled trial.' *Psychooncology*. 2010;19:21-8.

21 Report 44 – Elder abuse in New South Wales. https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report44ElderabuseinNewSouthWales.pdf

22 Australian Law Reform Commission. Elder Abuse – A National Legal Response. ALRC 2017. https://www.attorneygeneral.gov.au/Mediareleases/Pages/2017/SecondQuarter/Building-the-national-response-to-elder-abuse.aspx

23 Chochinov, *op.cit*.

Appendix A

Archbishop's Working Group on Voluntary Assisted Dying

Terms of Reference

The issues the Working Group have been asked to consider are:

(a) a Biblical and theological understanding of:

  (i) the sanctity of life;

  (ii) historical Christian views on whether it is legitimate for a person to take their own or another person's life (and, if so, when);

  (iii) obedience to the law of the land; and

  (iv) the injunction to care for the vulnerable,

  as applied to the provisions of the Act requiring an aged care provider to allow voluntary assisted dying to occur in its residential aged care homes.

(b) if Anglicare complies with Act and permits, and does not hinder, a permanent resident accessing voluntary assisted dying services from a third party, is Anglicare complicit in the delivery of the services in a way which would be contrary to the teaching of the Bible?

(c) should Anglicare take actions to dissuade or prevent permanent residents from accessing voluntary assisted dying services? If so, what is the range of Biblically and theologically informed actions Anglicare should consider?

(d) if Anglicare takes all legal steps to:

  (i) advertise that it does not agree with nor provide voluntary assisted dying services;

  (ii) inform residents of alternatives to voluntary assisted dying such as palliative care; and

  (iii) facilitates access to information and delivery of palliative care services,

  is that a sufficient response despite still having to allow access by third parties who will provide voluntary assisted dying services? If not, what additional steps should Anglicare take?

(e) if by complying with the Act, Anglicare would be complicit in the provision of voluntary assisted dying services, what other Biblically and theologically informed responses should be considered by Anglicare in relation to;

  (i) Anglicare's residential aged care services;

  (ii) Anglicare's home care services; and

  (iii) the provision of independent retirement living accommodation?

The Working Group may refine, narrow, or augment these questions in its early meetings to ensure the breadth of relevant issues are considered.

Appendix B

Anglicare's position on palliative care

1. Anglicare is deeply committed to excellence in the delivery of end-of-life palliative care services that holistically support a person's physical, emotional, and spiritual wellbeing through the last stage of life. Anglicare has a nurse-led, palliative care team who assist our residential and community-based aged care staff, to provide exceptional end-of-life care to our residents and clients. Anglicare considers physician assisted suicide and euthanasia to be the antithesis of this approach.

2. Anglicare believes that every person is uniquely made in the image of God and has dignity and worth, whatever physical or mental capabilities they possess or whatever circumstances in which they find themselves. For people who are nearing the end of their lives, and/or experiencing physical or psychological pain, a dignified and enriched life includes a right to receive or refuse medical treatment and to be accepted and well cared for by our community.

3. A person's autonomous decisions cannot be viewed in isolation from their relationships, and the expectations placed on them by family, carers, friends, and the community at large. People who are facing life-limiting (terminal) illness have no less dignity and worth in our community than their healthy counterparts, and we resolve to care for people in this situation by restating that they have value and purpose as individuals and as part of our community, even amidst pain and grief. They are not a burden to us, and they are not a burden on our society. We seek to uphold their value and worth by providing excellent palliative care services and honoring a person's decisions regarding their wishes should their body require treatment of significant symptoms, such as pain.

4. We support the process of natural dying, which includes the management of significant symptoms (pain, breathlessness, nutritional needs). The level of intervention required for any individual is based on a collaborative decision between the person dying and their treating physicians. Whilst we are aligned with the Act's intention to provide choices to a person facing a life-limiting illness, we do not agree that dignity and compassion are embedded in a decision to end a life through an act of administering a poison through voluntary assisted dying. We believe that dignity and compassion in such circumstances includes:

    - *Active empathy*: we attempt to understand a person's feelings, experiences and wishes, and act accordingly to assist in supporting their living. We understand and appreciate a person's desire to refuse treatment that would prolong their life and support them in that choice by providing a palliative approach to their care which aims at comfort, inclusive of promotion of advanced care planning.

    - *Honoring a dignified and enriched life*: we speak and act upon our belief that a person who requires intensive physical and/or psychological support is not a burden to us and continues to have inherent value and worth as a person and member of our community. We reinforce to all our residents and clients in this situation that they are valued by us and the community, even when they feel like their lives may be burdensome to others.

    - *Excellent palliative care support*: we provide services to people in residential care homes or in their own homes to compassionately provide comfort and accompaniment and to relieve their physical and psychological pain with a holistic approach.

Although residential care facilities are places of specific health care delivery, at their best our facilities are *homes* for those who live there. For our residents we desire that they find a home within these communities alongside other residents, staff and visitors which are places to experience consistent life-affirming care and to live well to the end.