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Voluntary Assisted Dying in NSW:

Pastoral Guidance and Theological Reflections for Sydney Anglican Diocesan Ministry Workers

1. Introduction

Voluntary Assisted Dying (VAD) became available in NSW on November 28, 2023. The advent of this practice will have significant practical and ethical implications for Christian ministry. Families and friends will be faced with choices that not only were they previously protected from by law but that they may have considered unthinkable in the past. Church workers will be asked for advice about difficult situations. Christian healthcare and aged-care workers will find themselves encountering patients wanting information about or requesting VAD. Clergy will be asked to conduct funerals for those who have died by VAD.

This document seeks to be a biblically faithful and theologically thoughtful resource to assist those in ministry leadership within the Diocese of Sydney in responding to VAD related matters in the pastoral setting.

The audience it has in view are clergy, licensed lay workers, and other vocational ministry leaders. It is not a confidential document; but it is also not written for a wider audience. Because VAD is a new development within NSW, this document is intended to only be an initial resource for ministry workers. It will likely need to be improved, expanded, or supplemented over time. However, it is also intended to be a resource that will assist clergy and ministry workers to proactively discuss and address VAD together, and so develop their own pastoral resources, materials, and policies for their own context.

2. Imagining some pastoral scenarios

To begin considering how we might respond to the impacts of VAD, it is helpful to imagine a range of scenarios that might be faced in the church context. We will refer back to these scenarios later in this document (Section 5).

Consider the following:

i. Valerie is an elderly widow who has been a member of your church for 40 years. Two weeks ago, she was diagnosed with terminal pancreatic cancer. Valerie lives alone and she is overwhelmed with the implications of this diagnosis. Will she need to move out of the home she's lived in for 50 years and into residential care? Is there home help services she might be able to secure? Will they be sufficient as her condition degenerates? Who will help her do all that research and handle all those arrangements? Valerie doesn't want to spend

the final months of her life in hospital. She's fearful of dying largely alone and in pain. She confides in you that she can't help but think VAD may be the solution to so many of her fears and concerns.

ii. Zhang is a 44-year-old male member of your church. He asks to meet with you and tells you that his non-Christian father has terminal brain cancer. The other night, Zhang's father told him and his sister Jia that he has started the VAD assessment process. Jia isn't a Christian and has told her father and mother that though she is devastated at the thought of losing him, of course she will support his decision. Zhang doesn't know what to do or say. If he says that he cannot support his father's decision to take his own life, he knows his sister will be furious, his mother will be distraught, and his father will likely draw away from him relationally. Zhang is terrified that his father might die angry at or disappointed in him. He struggles to hold back his tears as he asks you what he should do.

iii. Along with her husband Paul, Mary has been a servant-hearted member of the morning congregation for 25 years. She has had a long struggle with depression and her existing lung disease has now been classified as advanced and terminal. While she has thought about suicide in the past, she has never actually tried to take her own life. But this time is different. She considers her quality of life now so poor and her fear of the future so great that she has initiated the VAD assessment process. Paul is distraught. He cannot support her decision and has told her that he will not have any part of the process at all. She calls you to say that she already knows and respects that you will almost certainly not support her in this decision. But she wants to ask you to consider one thing. Paul has said that he won't be at her side when the substance is administered. She is terrified of dying alone and desperately wants you, her church minister, to hold her hand and pray for her as she dies.

iv. Aditya is a Christian who attends your evening congregation. She works as a nurse with a private palliative care centre that provides specialised end of life care for those who are not elderly. She considers it a privilege to be able to care for these relatively young men and women as they near the end of their life, and typically develops deep and trusting relationships with them. But as a Christian she's struggling. Several of her patients have recently been asking her for information about their VAD options. Her organisation has clear policies on this, requiring her to convey the request to the manager, who organises an authorised medical practitioner to come and speak with them about it. None of those patients have yet gone ahead with VAD, but Aditya knows that one day it will happen. When it does, she worries that she will feel complicit in their death. The thought is causing her enormous anxiety and she asks you to help her think wisely and biblically about all this.

v. James is your rector's warden and a bible study leader in your morning congregation. His sister, Sarah, was diagnosed with Motor Neurone Disease three years ago. Her condition is now rapidly deteriorating. For the last two years she has lived with James, his wife

Stephanie and their two children. Over coffee one day you ask James how Sarah is. He tells you that she has made the decision to end her life via self-administered VAD. She doesn't want anybody else to have to bear that responsibility and so is set on doing it herself while she is still able to do so. James continues that, of course, he has not actively supported her decision. He even tried to persuade her not to go through with it. But her mind is made up. Even though he can't support her decision, he loves her and so when she asked him to be her appointed 'contact person' he agreed. He explains that being a 'contact person' means he will receive the VAD substance from an authorised supplier on Sarah's behalf. He needs to keep it in a locked steel box until Sarah is ready to self-administer it. On that day he needs to prepare it for her if she can't manage that part herself. Then, after she has self-administered the substance and died, he needs to collect any of which remains unused and give it to an authorised disposer. He also needs to notify Sarah's coordinating VAD practitioner of her death.

vi. You are asked to take the funeral of John, a man who has been rather distantly connected to your church over the years. When you meet with the family you discover that he died by VAD. Some members of his family seem very pleased about this. Others seem quite conflicted.

vii. Van, a bible study leader at your church, has just informed you that he has resigned from his job as a nurse in an aged-care facility. Although he did not have to be involved in VAD, he felt compromised by being part of the system at all and in the end felt he could not continue. He is wanting the support of his church community, but he is also highly critical of Christian colleagues who have decided to remain within the system.

3. Understanding VAD

In order to move towards a thoughtful, faithful response to situations such as those above, it is important to have some appreciation of the NSW legislation, and where it is situated in our context.

The Act and its implementation

The Voluntary Assisted Dying Act 2022[1] was passed by the Parliament of New South Wales on 19 May, 2022. As noted above, the Act took effect on 28 November 2023. Many details of its implementation are still being determined.

[1] Voluntary Assisted Dying Act 2022, No 17: https://legislation.nsw.gov.au/view/html/inforce/current/act-2022-017#

VAD is the term used in the Act to describe the process by which an eligible individual may choose to end their life through the administration of an approved and prescribed poison (known as a VAD substance).

According to the currently legislated eligibility criteria (see, Part Two §16 of the Act) an individual is eligible for VAD if they:

- Are over 18 years of age
- Are an Australian citizen or a resident of Australia for at least 3 years, and who normally has been a resident of NSW for at least 12 months
- Are diagnosed with at least 1 disease, illness or medical condition that-
    i. is advanced, progressive and will cause death, and
    ii. will, on the balance of probabilities, cause death –
        a. within 12 months if it is a disease, illness or medical condition that is neurodegenerative (with the exception of a diagnosis of 'dementia' by itself)
        b. or within a period of 6 months for all other diseases, illness or conditions
    iii. is causing suffering to the person that cannot be relieved in a way the person considers tolerable,
- Have decision-making capacity in relation to voluntary assisted dying (see below)
- Are acting voluntarily and not because of 'pressure or duress' (defined in Schedule 1 of the Act)
- Make an enduring request to access VAD

According to the current legislation (see, Part Two §16:2 of the Act), an individual is not eligible for VAD:

- On the sole basis of having a disability or dementia, or a mental health impairment.
- If they permanently lose decision-making capacity partway through the process of pursuing VAD.

Once initiated by an eligible individual, the process of VAD involves several eligibility reviews/assessments by at least two qualified medical practitioners.[2] The individual may stop the process at any time. However, there are limited reasons why a request/assessment for VAD may legally be refused by a medical practitioner. If at the end of the process an individual is assessed as eligible and wishes to enact VAD, the individual chooses for either a qualified practitioner to administer the VAD substance to cause death, or the individual may self-administer the VAD substance to cause their own death.

An accessible overview of VAD-related information (including eligibility), as well as some of the implications of the Act for the NSW community and health practitioners is provided by NSW Health.

It is important to note that ministry workers are under no obligation whatsoever to provide any information about VAD to someone who might request it of them or raise the matter with them.

[2] Detailed information about the full process is found in the Voluntary Assisted Dying Act 2022 No 17, Part 3: https://legislation.nsw.gov.au/view/html/inforce/current/act-2022-017#pt.3

Terminology

The Act uses the terminology of 'practitioner-administered' VAD and 'self-administered' VAD. In the past, this distinction has usually been made by the terms 'Euthanasia' and 'Physician-Assisted Suicide'. See Appendix A for more information about these terms.

It is important to be aware that the terms used will almost certainly impact our moral evaluation of the practices in view. The terminology of VAD aims to distance the practices involved from the ideas of suicide and killing. The Act is clear that, legally speaking, a person who dies by VAD does not die by suicide. From a moral perspective, however, there is no basis for this distinction.[3]

Palliative care and VAD

Misunderstandings abound about the nature and purpose of palliative care. Because of this, it is worth being clear about palliative care and its relation to VAD. Palliative care is a specialised type of healthcare service that is defined by the World Health Organization as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.[4]

Palliative care affirms life and regards dying as a normal process. It offers a support system to help patients live as actively as possible until death. It intends neither to hasten or postpone death, and is therefore not a form of euthanasia, physician-assisted suicide, or VAD. Palliative care should be encouraged in the end-of-life situation to improve the quality of life of the person with terminal illness, and to provide support for the family and carers.[5]

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[3] For more on this point see Andrew Errington, 'Against "Voluntary Assisted Dying"'. The Centre for Christian Living, 2021: https://ccl.moore.edu.au/resources/against-voluntary-assisted-dying-andrew-errington/

[4] World Health Organization 'National cancer control programmes: Policies and managerial guidelines', 2nd ed. Geneva, 2022.

[5] Unfortunately, the implementation of VAD in New South Wales is likely to have significant ongoing implications for the provision of high-quality palliative care for terminally ill patients within an aging population. See, for example: Palliative Care New South Wales, 'Palliative Care funding attracting important attention', October 17, 2023: https://palliativecarensw.org.au/palliative-care-funding-attracting-important-attention/. Of particular concern is the possibility that rural and regional areas will have reduced access to palliative care services. The material health measures listed in the 2023/24 NSW budget included the enablement of 'safe and equitable access to voluntary assisted dying for eligible people in New South Wales, including particular focus on equitable access for regional and remote populations', while making no reference to the provision of similarly safe and equitable access to palliative care for NSW residents. See NSW Government, 'NSW Budget 2023-24: Budget Paper No.01', A5-6: https://www.budget.nsw.gov.au/sites/default/files/2023-10/2023-24_01_Budget-Paper-No-1-Budget_Statement_v2.pdf

The Australian and New Zealand Society of Palliative Medicine has stated quite clearly that the discipline of palliative medicine does not include the practice of VAD (although individual practitioners may choose to be involved on a personal basis).[6]

Mentally competent patients in Australia have the right to refuse life-sustaining treatments including the provision of medically assisted nutrition and/or hydration. Refusing such treatment does not constitute euthanasia, physician-assisted suicide or VAD, as death will be due to natural causes. Similarly, withholding or withdrawing treatments that are not benefitting the patient is not euthanasia, physician-assisted suicide or VAD. Treatment that is appropriately titrated to relieve symptoms and has a secondary and unintended consequence of hastening death, is not euthanasia, physician-assisted suicide or VAD. (Opioids such as morphine, when given in therapeutic doses, do not hasten death). Instead, euthanasia, physician-assisted suicide, or VAD involves a deliberate act which directly and intentionally causes the individual's death.

Why people may choose VAD

The dominant societal narrative in support of VAD maintains that the majority of those who wish to end their life in this way do so out of a desire to avoid or end unbearable pain and suffering. Yet in jurisdictions where VAD (or similar) is legal, intolerable physical suffering does not even rank as one of the top 5 reasons why people request it. Instead, a motivating factor is more often psycho-social problems.[7]

Recent Australian data shows that only approximately 2% of patients in palliative care units experience pain at the end of life.[8] When patients nearing the end of their life are provided with adequate palliative care, pain alleviation and psycho-social support only a small minority express a preference for euthanasia.[9] Such data suggests that, contrary to popular claims, it is not always or usually untreatable

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[6] Australian and New Zealand Society of Palliative Medicine, 'Position Statement: The practice of Euthanasia and Physician-Assisted Suicide', 2021: https://www.anzspm.org.au/common/Uploaded%20files/Position%20Statements/2%20ANZSPM_Position_Statement_Euthanasia_Physician_Assisted_Dying.pdf

[7] 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', Psycho-Oncology, 2010; 19:21-28.

[8] Connolly A, Bird S, Allingham S et al. 'Patient outcomes in palliative care in Australia. National Compendium Report January – June 2016', Palliative Care Outcomes Collaboration. Australian Health Services Research Unit, University of Wollongong, NSW, Australia, 2016; Clark K, Connolly A, Clapham S et al. 'Physical symptoms at the time of dying was diagnosed: a consecutive cohort study to describe the prevalence and intensity of problems experienced by imminently dying palliative care patients by diagnosis and place of care', Journal of Palliative Medicine, 2016, 19(12).

[9] 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).

pain and suffering that primarily motivates people to request euthanasia. Rather those who seek out euthanasia often lack awareness of or confidence in the palliative care options available to them; lack access to appropriate palliative and psychological care; or see their need for ongoing medical, social and relational care as placing an unnecessary burden on their loved ones and wish to 'solve' this. The dominant narrative of VAD as a necessary act of compassion for those enduring great pain and suffering at the end of their life needs to be examined anew.

The importance of such a re-examination is heightened by the fact that data from other jurisdictions reveals that, once legalised, euthanasia rates tend to continually increase over time. For example:

- From 2002 to 2019, euthanasia rates more than doubled in the Netherlands.[10]
- Canada has seen a ten-fold increase in MAID (Medical Assistance in Dying) deaths since its legalisation in 2016. This represents an increase of approximately 33% every year.[11]

The legalisation of VAD (or similar) is the first necessary step towards its ever-increasing normalisation as a seemingly legitimate way to end suffering (whether physical or otherwise) and respect a patient's personal autonomy over their own life.

Because the 'social contagion' effect of suicide is well-documented, the timing of VAD's legalisation in NSW is especially problematic. Mental illness and psycho-social isolation are at an all-time high amongst many Australians, and especially young adults.

Concerns about safeguarding the vulnerable

Certain aspects of NSW's VAD Act 2022 lack adequate safeguarding measures to protect vulnerable members of society. For example, the legislation presumes a VAD patient's decision-making capacity is intact unless otherwise shown. Even though research demonstrates that cognitive capacity is known to be negatively impacted by physical illness and poor health,[12] no psychiatric assessment is required to determine a VAD patient's mental competency at the time of their decision.

In addition, mental illness is not a disqualifying factor for a person deciding to end their life via VAD. This lack of safeguarding is particularly concerning because research correlates depression and other

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[10] 'Unexplained 7-Fold Variation in Euthanasia Rates across the Netherlands,' BMJ Publishing Group, January 14, 2021: https://www.bmj.com/company/newsroom/unexplained-7-fold-variation-in-euthanasia-rates-across-the-netherlands/.

[11] 'Mental Health and MAID: Canadians question looming changes to Canada's assisted-death law,' Angus Red Institute, February 12, 2023: https://angusreid.org/wp-content/uploads/2023/02/2023.02.13_MAID.pdf

[12] For example, see Breitbart, W. 'Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer.' *Journal of the American Medical Association*, Dec. 13, 2000: 2901-11; 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): 337-43.

poor mental health conditions with increased rates of suicidal ideation. Research also evidences dynamic decreases in suicidal thoughts and tendencies as mental health is itself treated.

The elderly (a demographic group with a strong proportional representation in our churches) are particularly vulnerable to inadequate VAD safeguarding. Elder abuse is under-studied and under-reported in Australian society.[13] The limited data which is available suggests that around one in twenty people in NSW who are above the age of 65 have experienced some kind of elder abuse.[14] Elderly women are far more likely to be victims of this abuse than men (one international study suggests up to 20% of elderly women suffer neglect)[15] and 71% of abusers are family members and relatives.[16] There is a very real and present danger that elderly members of our church communities and broader society may feel pressured towards or be coerced into a decision to enact VAD even as, speaking from a sense of family loyalty, they may insist to those assessing their request that this is not the case.

Finally, in several overseas jurisdictions with a longer history of legalised euthanasia, changing ideology and practice have resulted in a widening of the criteria for inclusion. This has resulted in further exposure of vulnerable people to VAD-related abuse, including children, those living in poverty and economic isolation and those suffering from mental illness and other non-terminal illnesses.[17] Canada, which legalised assisted suicide and euthanasia in 2015, has seen a rapid and troubling expansion of the practice and widening of the criteria for eligibility.[18]

Churches have a vital role to play in providing strong relational connection, steadfast practical support and committed pastoral care for all who may feel drawn towards VAD for fear of being an unwanted burden on their loved ones or society at large, or for feeling that they have no chance at a 'normal life'. No-one should choose VAD due to a lack of care or love.

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[13] Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. General Purpose Standing Committee No. 2, 'Report No. 44 – Elder abuse in New South Wales'. NSW Legislative Council, 2016, 6: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2387/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf

[14] General Purpose Standing Committee No. 2, 'Elder abuse in New South Wales', 2016, 7.

[15] Australian Law Reform Commission. Elder Abuse – A National Legal Response. ALRC, 2017, 37: https://www.alrc.gov.au/wp-content/uploads/2019/08/elder_abuse_131_final_report_31_may_2017.pdf

[16] General Purpose Standing Committee No. 2, 'Elder abuse in New South Wales', 2016, 7.

[17] See especially the studies in David Albert Jones, Chris Gastmans, and Calum MacKellar, eds., *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press, 2017).

[18] See Coelho R, Maher J, Gaind KS, Lemmens T (2023), 'The realities of Medical Assistance in Dying in Canada', *Palliative and Supportive Care*, 1–8: https://doi. org/10.1017/S1478951523001025

VAD and the Anglican Diocese of Sydney

The Anglican Diocese of Sydney has consistently opposed the legislation of these practices on grounds of principled opposition and good public policy. The 3rd session, 52nd Synod passed resolution 5/22 in direct relation to VAD, reaffirming:

…the principled and continuing opposition of the Sydney Diocese of the Anglican Church to euthanasia or physician assisted suicide, because these practices –

i. are prohibited by the sixth commandment, forbidding murder,
ii. are a threat to the safety and well-being of the most vulnerable in our society,
iii. overturn the ethics of medicine and health care,
iv. undermine the need to provide adequate and appropriate palliative care to all Australians, irrespective of who they are or where they reside, and
v. are opposed by all faiths, including Christianity, that share belief in the sanctity of life,

The 1st session of the 53rd Synod passed resolution 11/23, which included the following:

> Synod, noting the report 'The commencement of voluntary assisted dying in NSW' –
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> …
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> (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,
>
> (a) …
>
> (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,

These synod resolutions signal some of the reasons why Christians have opposed euthanasia and physician assisted suicide. It is important to understand how these reasons fit together and flow out of the good news of Christ. The following section sets out the starting point for all the pastoral considerations that follow.

4. Death, the gospel and suicide

Our pastoral responses to VAD must be shaped by the gospel message and what it means for all forms of suicide.

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 to face judgment' (Heb. 9:27; cf. 1 Pet. 4:6). 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 (Deut. 32:39). We, alongside all creatures, stand in utter dependence upon Him (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 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). Christ's conquest of death (Rev. 1.17–18, 1 Cor. 15:57) 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.

Christian thinking about suicide – of which different forms of 'voluntary assisted dying' should be considered species – should begin from this understanding of life and death, the fear of death, and the gospel's promise of freedom and life in Christ. Suicide is a complex and tragic reality, but the gospel can enable Christians to speak about and to this complexity and tragedy with compassion, courage, and clarity.

To the despair of suicide, the gospel speaks a word of hope. It says that in Christ there is forgiveness and power, a path to walk in faithfulness through darkness, a community to walk within and beside, and the promise of a future of unimaginable joy and glory, where God will wipe every tear away (Rev. 21:4). It urges perseverance, even in the face of great dismay and confusion, and assures us that however terrible our sufferings may be now – and they can be very terrible – they are not worth comparing with the glory about to be revealed in us (Rom. 8:18).

In suicide there is also, however, an element of defiance. This defiance can itself be complex. There is something understandable in the desire to refuse to let one's life be defined by mental anguish, deteriorating cognitive or bodily function, or physical pain. It represents a distorted kind of affirmation of what is good and of the gift of life. Yet there is also an element of pride in such defiance, for fundamentally it represents a refusal of our condition as creatures: creatures who must die, and who do so as sinners. The defiance of suicide refuses God's right as Creator to give and to take life, and seeks

to control life on our terms. It represents a loss of faith in God's grace as Redeemer to sustain perseverance and hope in the face of suffering and despair through the promise of life in Christ Jesus.

For this reason, suicide should be clearly named as a sin. The wrongfulness of suicide is marked out in the law 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. As such, the Christian tradition has consistently understood it to apply to suicide, as that which constitutes a kind of 'self-murder'. As Augustine's put it: 'if no one has a private right to kill even a guilty man … then certainly anyone who kills himself is a murderer'.[19] The sixth 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 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). These considerations have led Christians to consistently oppose all forms of suicide, including the practices of physician-assisted suicide and euthanasia, in the strongest terms, as essentially varieties of murder.

To simply insist that suicide is wrong is of course much less than what is needed for a pastoral response to suicide and the practice of VAD. The complexity of lives that end in suicide must always be kept in mind, and theologians and pastors have often wanted to stress the need for a word of grace, and not just law, especially at this point. Dietrich Bonhoeffer cautioned that, 'One who despairs of life can be helped only by the saving deed of another, the offer of a new life which is to be lived not by his own strength but by the grace of God'.[20]

Nonetheless, pastoral practice is assisted, rather than impeded, by clarity on the foundational principle of the wrongfulness of suicide, even if there are many further issues to discuss, most especially including the challenges of mental ill-health and physical suffering. The principle is of great importance when it comes to issues of public law and institutional practice.

5. Pastoral reflections

With this starting point in mind, let us now return to the scenarios imagined at the beginning of this document, in section 2. These imaginary situations make it apparent that VAD has the potential to raise a range of issues, some less and some more complex.

The challenges of the first scenario (Valerie) are primarily practical and pastoral. It clearly calls for a gospel ministry of comfort and help, for instruction about the path to which God calls us accompanied by understanding and compassion for this person's difficulties. Above all, it is an invitation to the

[19] Augustine, *City of God* I.17 (trans. H. Bettenson; Penguin, 1984), 27.

[20] Dietrich Bonhoeffer, *Ethics* (Simon and Schuster, 1995), 168.

minister and the community not to abandon a brother or a sister at the end, but to walk with them even through the valley of the shadow of death, seeking to support them practically, morally, and spiritually.

The second scenario (Zhang) surfaces the potential impact that VAD may have on families whose members see things differently. It asks us to think about what it would mean to honour our parents in such a situation and confronts us with the possibility that Christ's call to follow him may divide us even from those we hold most dear. It is also an example of a case about which we can imagine people coming to different judgments, in slightly different circumstances, about what to do. This raises the question of conscience and disagreement among Christians.

The third (Paul) and fourth (Aditya) scenarios raise the issue of 'complicity'. Would it be somehow compromising or improper for a minister to be with someone, as they died by VAD? Might that represent a kind of endorsement, or at least insufficient clarity about the wrongness of this course of action? Again, we can imagine Christians disagreeing on such a matter. One might feel it critical to remain with someone, in order to continue to speak the gospel to them to the end. Another might feel that such an act would inevitably only serve to ease the person's conscience when it ought not be eased. In the fourth scenario we have to ask whether the workplace policy with which Aditya is required to comply means she should not feel compromised in passing on the request, or whether her involvement remains problematic. In addition, there is the question of her own conscience and how that bears upon her choices.

The fifth scenario, in addition to raising questions about whether James's decision represents an inappropriately active support for his sister's choice, potentially raises questions about the consequences for James. Should James continue to serve in leadership, having made this decision?

In the sixth scenario (John), the minister involved would have first to decide whether to conduct the funeral. If he or she did, they would have to then decide how to do so in a way that did justice to their own convictions and served the people involved well.

The final scenario (Van) highlights the way people might come to different judgments about some of the questions raised by VAD. It raises questions both about how we should think about our participation in systems involved in doing things that are wrong, and how we should respond to differences of judgment within the Christian community.

It is beyond the scope of these guidelines to engage with all the matters raised by these scenarios. As discussed at the beginning of this document, clergy and ministry leaders will need over time to develop their own thoughtful and faithful approaches to VAD's pastoral implications. However, these scenarios particularly highlight that greater clarity about two key issues – complicity and conscience – may assist such endeavours. The following section considers these issues in a little more detail.

Complicity

As we have seen, one of the ideas that may come to mind as people are thinking through their response to the new VAD legislation is the notion of 'complicity'. The idea of complicity appears to capture a

sense in which we can be ‘objectionably involved’[21] in an immoral act without being held directly responsible for it. However, it is important to be more precise about exactly what we are talking about with the notion of complicity.

Complicity is first and foremost a legal concept which has very specific qualifications in law. When people speak of complicity in the context of VAD, this is clearly not what they mean, because the legalisation of VAD means it is no longer a crime.

But a more general, moral sense of complicity is hard to pin down and not always particularly useful for making decisions. We need to think carefully about how and why someone might be implicated in the immoral action of another person. And so, at this point, it is important to distinguish real responsibility and meaningful participation from mere proximity or distaste. The mere fact that a person is near to or in some way involved in an action they disagree with or find objectionable, does not necessarily mean they are implicated in that action. A manager of an aged-care facility who is legally obligated to allow access to a third-party providing VAD services to a resident may find this deeply unpleasant and upsetting, but they are not necessarily complicit in this action in any meaningful sense. The responsibility for this clearly falls upon the law, the third party, and the resident. Similarly, a midwife who attends a mother during an emergency abortion despite her personal strong opposition to abortion is not necessarily complicit in that action, as she shares no responsibility for the decision to have an abortion and is there only to care for the mother. Likewise, Aditya might be reassured that she is not responsible for the policy her organisation has enacted.[22]

Many Christians will find these examples confronting and troubling. Their value lies in helping us distinguish mere proximity to evil from responsibility for evil. When Scripture calls us to ‘flee’ evil (e.g. 1 Cor. 6:18), it is calling us to flee evil that we might do, that is, be responsible for. It should not be understood, however, as calling for mere distancing from evils we find repellent, as if we might be made unclean by mere proximity to evil. The Christian life is not lived simply 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). No church, home, community, or aged care facility is free of evil; and we should beware of assuming that the presence of some particular evil, which has special public prominence, is uniquely corrupting.

That said, we should also beware overconfidence about this distinction, or about our capacity to make it. Scripture also warns believers, ‘not to be yoked together with unbelievers’, and to ‘be separate’. For

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[21] The phrase is taken from Neal Tognazzini and D. Justin Coates, ‘Blame’, Stanford Encyclopedia of Philosophy: https://plato.stanford.edu/entries/blame/#MorAge

[22] That said, even in a situation where one is not responsible for certain actions, it is possible to come to the conclusion that the presence of those actions corrupts the context for one’s actions in a way that becomes unsustainable. This possibility was explored by the Archbishop’s Working Group on Voluntary Assisted Dying when it explored the impact of the legislation upon Anglicare. See ‘Report of the Archbishop’s Working Group on Voluntary Assisted Dying’ in the First Session of the 53rd Synod: Proceedings for 2023, 290-301: https://www.sds.asn.au/sites/default/files/2023%20Synod%20Proceedings.complete.pdf?doc_id=NTM1NjQ=

‘what fellowship can light have with darkness’? (2 Cor. 6:14–18). Without falling into an assumption that we are rendered unclean merely by proximity to certain kinds of evil, it is wise to be cautious and circumspect about such proximity, and to be clear in our determination to ‘touch no unclean thing’ (2 Cor. 6:17).

Conscience and disputable matters

Given the complexity of navigating situations and circumstances, such as those above, it is inevitable that Christians will come to different judgements about what in each situation it is right to do. It may be helpful to think about some of these differences by analogy with the careful discussions of matters of disagreement we find in the New Testament.

In Romans 14–15 we see the apostle Paul navigating the complexities of disagreements over various aspects of obedience. The matters in question have to do with different evaluations of the significance of tangible activities like eating meat and observing festivals. What distinguishes these matters is that it is possible to appreciate how a person might make a decision either for or against each activity ‘to the Lord’ (Rom. 14:6). Paul makes it clear that it is possible to understand how a person might either eat or abstain ‘to the Lord’, ‘fully convinced’ in their own mind, and so acting ‘from faith’. This is one way to understand the idea of ‘conscience’: it is about one’s felt and experienced moral conviction about one’s action. In such situations, Paul insists, it is important to refuse the paths of mutual judgment and recrimination, recognising that the person and his or her faith is more than, and more important than, the particular judgment. Even though Paul himself has a clear opinion on the issues in question – he insists that all food is clean (14:14, 20) – he nevertheless argues that patience and restraint is called for in such circumstances, in order to protect the brother or sister with whom one disagrees.

This discussion helps us recognise that there are areas where moral disagreements may be, and indeed should be, endured rather than simply decided upon quickly. Such will be many of the disagreements precipitated by the impact of VAD legislation. Christians will come to different positions on what is right and wrong at various points. Sometimes, there will be no choice but to come to a decision. Organisations, for example, may need to make policies which include certain decisions. But within the life of churches and relationships with one another, there will be times when what is needed is patience, a willingness to hear and to accept one another, and the ability to keep in perspective the person as well as their judgments about some course of action.

The discussion in Romans 14–15 also shows, however, that this approach of enduring differences rather than swiftly resolving them is not an end in itself. It has its limits. Paul’s clarity about his own convictions shows that he expected there to be ongoing dialogue, and the hope of reaching a common mind. Moreover, there will be some differences of judgment that cannot be endured in this way because they cannot be imagined as alternative paths of obedience in the way Paul describes in Romans 14:5–8. There are moral questions on which different judgments cannot be tolerated within the Christian community, even when both judgments are held as matters of conscience.

This distinction is worth registering in relation to VAD. The issue will precipitate various kinds of differences in judgment. Some of these will be able to be endured while others will not. A church seeking to care for people and their families wrestling with VAD would not be able to accept both the view that euthanasia is an acceptable course of action and the view that it is not, because the attempt to tolerate both positions will itself be corrupting of the community and its witness. This is not a disagreement that will be able to be endured as a 'disputable matter', and it is therefore important for churches to consistently affirm that VAD is an unacceptable course of action. However, a church may be able to endure a difference in judgment over whether someone ought to be present at the death of a family member by VAD, or whether someone should resign their position if they are required to be involved in VAD in some way. In the case of these differences, the effort to understand the opposed position may enable us to care for one another better, rather than corrupting our ability to do so.

6. Conclusion and further resources

The introduction of Voluntary Assisted Dying is a development of potentially great significance for Christian churches and Christian ministry in NSW and further afield. For hundreds of years, public law protected people from the temptation to end their own lives or assist others to do so during suffering. This protection has now been removed, meaning that many will now have to face these temptations individually. The removal of these protections will also have significant implications for personal relationships amongst friends and family, for relationships within the Church and, potentially, for the relationship between Church and government. While this is a tragic development, it may also, in God's providence, open the door to new forms of witness to Christ and the good news of life that he brings. These guidelines are offered in the hope that they may assist in that witness.

Funeral resources

The following suggestions are offered as supplements to funeral services that may be useful in the case of VAD. The main aim of these liturgical offerings is to affirm the sovereignty of God over life and death.

Psalm 104, verses 27–30 may be a useful reading:

Psalm 104:27–30

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.

The following two prayers may also be helpful additions:

A prayer

Almighty Lord, Creator of heaven and earth,
You know our going out and our coming in.
Though we count our days, they are written in your book.
We are but dust, O Lord, and to dust we return.
And so in the face of death we cling to your mercy
and to the power of Jesus our Lord and his indestructible life.
Grant us humble hearts and a penitent spirit,
that we may never despair of hope or abandon faith,
until we come to your everlasting kingdom.
Thanks be to God who gives us the victory through Jesus Christ. Amen.

A prayer

Sovereign Lord,
It is given to human beings to die once, and after that the judgment.
Forgive us all our sins and failures.
Thank you that in Jesus Christ we find mercy and great hope,
and that your grace goes before and beyond all our failures.
As we leave our sister in your keeping,
teach us that our ways too are in your hand,
And give us the comfort of knowing that even though we lose faith,
You remain faithful, for you are always the same:
God of steadfast love, justice and mercy. Amen.

Further resources

Anglican Community Services, 'The commencement of voluntary assisted dying in NSW'. First Session of 53rd Synod: Proceedings for 2023, 287-301: https://www.sds.asn.au/sites/default/files/2023%20Synod%20Proceedings.complete.pdf?doc_id=NTM1NjQ=

Errington, A. 'Against "voluntary assisted dying"'. Centre for Christian Living, October 18, 2021: https://ccl.moore.edu.au/resources/against-voluntary-assisted-dying-andrew-errington/

Moll, Rob. The art of dying: Living fully into the life to come. InterVarsity Press, 2021.

Political Animals Podcast, 'Euthanasia: A Conversation with Dr Megan Best'. May 1., 2022: https://podcasters.spotify.com/pod/show/politicalanimals/episodes/Euthanasia-A-Conversation-with-Dr-Megan-Best-e1htcqp

Roberts, V. Assisted Suicide: Assisted Dying (Talking Points Series). The Good Book Company, 2016

Appendix A: Key terms and definitions

Euthanasia: A deliberate intervention, normally by a medical professional, undertaken with the express intention of ending a life to relieve intractable suffering.

Physician Assisted Suicide (PAS): When a competent patient requires help to enact the desire to end his or her life and receives this help from a doctor. This is distinct from euthanasia because the primary actor is the patient themselves.

Voluntary Assisted Dying (VAD): The language used in NSW legislation and several other jurisdictions to refer to an eligible person accessing medical assistance to end their life. This term seeks to distance this form of death from the language of suicide, as per the NSW VAD Act which specifies (12.1) that ‘a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide’. The NSW Act distinguishes between euthanasia and physician assisted suicide by speaking of ‘practitioner-administration’ and ‘self-administration’ of VAD substances. However, the actions involved are better described as euthanasia and physician assisted suicide.

Voluntary Assisted Dying Substance: A lethal dose of an approved poisonous substance supplied for the purpose of causing the patient’s death. This substance can be administered by an ‘eligible administering practitioner’ or it may be self-administered by the patient themselves upon it having been provided to them by an authorised supplier.