Voluntary assisted dying: an aged care chaplaincy perspective

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I am an aged care chaplain working in a large regional Lutheran care facility and its independent living community. Being South Australian, the VAD laws have only recently been enacted, and we have not yet journeyed with a VAD candidate. Our facility is close to finalising its policy and procedures on VAD. My own approach to VAD is aspirational rather than based on experience. And yet I've encountered people in the aged care and other settings who have longed for the opportunity to end their chronic pain and suffering through taking proactive control of the timing of their deaths.

Some people who live at my facility will probably seek to make the journey toward death via the VAD process. This may be rare, especially if people sympathetic to VAD choose not to live in our facility because they perceive us as being unsupportive of their choice. Nevertheless, people make our facilities their home, and as health declines, options arise that people perhaps hadn't considered before. We don't evict people when they make a lifestyle choice we might disagree with.

An organisation carrying the Lutheran name, and especially those like us who are owned by the Lutheran church, will abide by the ethical values of the Lutheran church. That is, *we do not support VAD, but we support people, especially people in situations of acute suffering*. How to negotiate our way between these two poles—'not'…'but'…—is the art of a Christian response to people choosing VAD. I hope we will seek to provide a level of care for those choosing VAD so the resident can 'die well', as we hope with any resident.

It seems that people are unlikely to choose VAD simply because of the risk of physical pain. Spiritual pain (feeling abandoned by God or his people); social pain (feeling lonely or abandoned); physical pain caused by inequity of resources, or poor lifestyle choices; and emotional pain (e.g. grief or fear hastening the person's desire to die), are factors that contribute to a decision to choose VAD. Palliative care acknowledges the many possible facets to people's suffering. Care of VAD patients will need to do the same. As we provide care on all these levels, we may even contribute to a resident changing their mind from going through with VAD, although that will not be our aim of care, anymore than good palliative care may hasten the dying journey. The approach to care will be multi-disciplinary and the chaplain is part of the team.

Daniel Fleming, a Catholic ethicist working in a Victorian hospital, has written a helpful paper titled 'Is presence always complicity? An analysis of presence, its moral objects, and

scandal in proximity to physician-assisted suicide and euthanasia.'[1] It is about the power of both presence and of absence which has helped me to form my, as yet theoretical, approach. Some points relevant to our situation are:

- *There is already an implied theme of presence simply in the reality of supportive VAD laws*. The Parliament is saying to people facing some almost-impossible life realities—'We hear you. We are with you.' People are considering VAD because of this encouraging presence of the Parliament.
- *The right words from churches can also express such positive presence*—The language of 'We don't support VAD but we support people' is already an offer to be present, and affirms the presence of God too.
- We need to recognise that *presence can be complicity* if handled wrongly by a chaplain or other member of the health team, for example, if a chaplain comes across as overly supportive of somebody considering VAD. Chaplains are authority figures who need to very carefully measure their potential to sway decisions for a very vulnerable person. Chaplains and the organisation and its policies need to collaborate carefully and transparently.
- *The type of presence needs to be transparent for the resident*. Clear communication of the church's stance and how the chaplain will work with that will assure the resident of consistency of care and hope for healing. Presence may be non-direct and prayerful if the resident does not want the chaplain to be physically present.
- If given permission to visit, *presence can then be like regular pastoral care for a person on a dying journey*, based on the premise that this person is a 'child of God, wonderfully made, with an eternal future' rather than simply a sick person defined by their illness or life choices.
- *If a resident experiences some physical healing*, or has a breakthrough in pain management, or makes a discovery that God really loves them after all, or finds a long-lost friend, *that resident may decide to revoke the decision for VAD. Chaplains will honour this decision just as they honoured the decision by the resident to proceed with VAD*. As positive care continues to be offered to such a resident, there may be times to sensitively celebrate with the resident, as we do with any person who experiences healing, granting that this resident, who was a candidate for VAD, is still likely to die within the expected time frame.
- *Presence will look different at different points of the VAD journey*, up to and including the last hours of life, plus looking forward to supporting the family, providing funeral services, etc.
- *Not being present, after the resident has requested presence, or assumed presence, can feel like abandonment*, and can risk adding to the resident's social or spiritual pain,

1 Daniel Fleming, 'Is presence always complicity? An analysis of presence, its moral objects, and scandal in proximity to physician-assisted suicide and euthanasia,' *Theological Studies* 82, no. 3 (Sep 2021): 487–508.

thus reinforcing their decision to proceed with VAD.

- *The Good Samaritan Story (Luke 10:25–37) is helpful in our context, as it includes the theme that sometimes the best care comes with some risk*, risk which can be minimised (e.g. the Samaritan traveler made it safely to the Inn with his patient). Risky presence does not have to be reckless.

In conclusion, Lutherans, and Lutheran care facilities, will be challenged to put their best effort into supporting people through crucial life situations, without supporting VAD itself. Care will be intelligent, collaborative and holistic. The art of being pastorally present is a powerful contribution to healing, which is why we involved ourselves in aged care in the first place.

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