Legalised Voluntary assisted dying is certainly a polarising and emotive issue. Some people have warmly welcomed its introduction in Victoria, others are dismayed. Others may be unsure about it. And some are confused about what it involves. Most of us would wish to be assisted as we are dying, this is part of the role of the health professions, and more particularly palliative care. But this is not what Voluntary Assisted Dying as defined in the Victorian legislation is about. It is about being assisted to die. So it includes both what has previously been called physician (or doctor) assisted suicide and voluntary active euthanasia. It means either a doctor on request prescribing a lethal ‘assisted dying substance’ (a combination of drugs) for a patient to take in order to end their life- which is doctor- assisted suicide, or, if the patient is physically unable to take the mixture orally, the doctor administering it by intravenous injection, which is euthanasia.

People are also sometimes confused about some standard medical practices which they think are a form of euthanasia, but which are and have been perfectly legal in Victoria for many years. The first of these is when a patient dies after medical treatment is withheld or withdrawn. For example, not starting antibiotics for pneumonia in a frail or demented elderly person; discontinuing dialysis, or withdrawing artificial ventilation in the ICU, or (more controversially) withdrawing artificial nutrition and hydration, sometimes called tube feeding. There is a long tradition in the law, medicine and moral philosophy of making a distinction between killing and “letting die.” And the medical profession continues to maintain a clear distinction between ‘letting die’ in appropriate circumstances and giving a patient a lethal injection or assisting their suicide by providing them with lethal drugs.

Another standard medical practice that is sometimes confused with euthanasia is the administration of pain relief to patients in the last days or hours of their life, when there may be uncertainty as to whether this might shorten the patient’s life. Traditionally, this is justified by the Principle of Double Effect (PDE), if the intention is not to cause death, but rather death might be foreseen. Again, medical practice and the law have long distinguished between this, which is permissible, and both euthanasia and doctor-assisted suicide.

Assisted dying, like many ethical issues, is complex, with a variety of competing arguments which need to be weighed up. Those who understand and appreciate the competing arguments may nevertheless come to different final conclusions on an issue because they give different weight to the various arguments. They might fully recognize the strength of arguments for a position which they ultimately oppose, and the need to take these arguments into account. A powerful argument may not be the decisive or winning argument, but it is no less powerful for that, and we must still take it into account.

I think there is general agreement that the moral principles which are relevant in assisted dying are, on the one hand, the alleviation of suffering and respect for individual autonomy, and on the other, the sanctity of human life, and justice, The sanctity of human life is fundamental in the Christian tradition, based on the belief that all people are made in the image of God, but it is also recognised in the law and common morality. Justice, from a biblical perspective includes specifically protecting the interests of the vulnerable, the importance of which, again, is not restricted to the Judeo-Christian tradition. How these principles of the relief of suffering, respecting autonomy, the sanctity of human life and justice are balanced will determine whether one agrees with legalised assisted dying or not. But whichever side we come down on, all these principles need to be taken into account. So, health professionals who and health institutions which refuse to be involved in voluntary assisted dying need to do everything they can to relieve suffering and to respect patient’s choices. This in fact has always been central to palliative care, which aims to assist patients to die with comfort and dignity. On the other hand, those who support assisted dying and/ or are willing to be involved in it need to ensure as far as possible that it does not result in a loss of respect for human life or unjustly risk the lives of the vulnerable.

Therefore, this legislation comes with certain criteria for eligibility o to access assisted dying, and certain safeguards. The criteria include that the patient must be over the age of 18, that they must have capacity to make decisions about their own medical treatment, they must be diagnosed with a disease, illness or medical condition that is “incurable, advanced, progressive and is expected to cause death within less than 6 months” (or 12 months for patients with neurodegenerative conditions such as motor neurone disease and multiple sclerosis). Suffering as a result of mental illness or disability alone does not satisfy the eligibility criteria, although the presence of mental illness or disability does not preclude someone who otherwise meets the criteria from accessing it.

Two major safeguards in this legislation are that a doctor may not raise the possibility of assisted dying with the patient, and that if the patients raises it, the doctor must be satisfied that the patient is making a voluntary decision, free from coercion. However there is considerable doubt about how easily such coercion, for example from family members, will be to detect. Our context is one where elder abuse is prevalent and notoriously difficult to detect.

There is also one major safeguard that is missing from the Victorian legislation. Many people who support ‘assisted dying’ do so because they assume that it will only apply for patients with extreme, uncontrolled pain or other physical symptoms. But the legislation does not require that a patient has pain or any physical symptoms, only that they “be experiencing suffering that cannot be relieved in a manner that the person considers tolerable.” And when we look at thereasons why patients access assisted dying in overseas jurisdictions where it is legal, pain is not the primary reason**.** In Oregon, where doctor-assisted suicide has been practised for round twenty years, less than a third of the patients who requested ithad or were in fear of inadequate pain control. Instead, what motivated them were psychological factors: “depression, hopelessness, being tired of life, loss of control and loss of dignity.” Similarly, in the Netherlands, few patients receiving euthanasia had physical pain, but a majority were depressed. Yet in both Oregon and the Netherlands very few patients are referred to a psychiatrist. If there are often mainly psychological reasons behind a request for assisted dying, a reasonable safeguard would be psychological evaluation and treatment, but under the Victorian legislation no such assessment is required unless the person’s decision-making capacity is in doubt, which would only occur in very severe mental illness.

The Victorian legislation provides for conscientious objection on the part of health practitioners and indeed whole health services. It recognises that many will not be involved, and though this is often cast in terms of people having religious objections, in fact many doctors will object because they believe assisting people to die is no part of good medical practice. It represents a radical departure from medical ethics. In other words, apart from the general ethical arguments for and against assisted dying, doctors have particular reasons not to kill their patients that arise from the nature of medical practice itself.

Medical opposition to euthanasia and assisted suicide goes back to the Hippocratic *Oath* from the 4th century BC and continues in the official position statements of the vast majority of medical associations today, including the World Medical Association. The AMA position statement on euthanasia and physician assisted suicide, while recognising that there are divergent views within the medical community, says that “doctors should not be involved in interventions that have as their primary intention the ending of a person’s life.” It is expected that only a small minority of doctors in Victoria, and not all hospitals will be willing to be involved in voluntary assisted dying, which has already raised concerns among advocates for the practice that patients may have difficulty accessing it.

The position statement of the American Medical Association is particularly interesting since it has been very recently updated, and continues its opposition to ‘assisted dying’ despite assisted suicide is being legal in ten US States of the U.S. I quote: “It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However…. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”

To conclude, this legislation should prompt us to think about our role as members and perhaps leaders of our communities, including Christian communities, and to think about what kind of communities we want to be. I think this is a major challenge for us. Whether we agree or disagree with assisted dying, the challenge is to form communities which embody in practical ways our affirmation that all human lives are valuable, including those of the disabled, the elderly and the terminally ill. I hope we can all agree that no one should be forced, because of pressure from their families, loneliness and/or lack of availability of quality palliative care or mental health services to reach such a point of desperation and hopelessness that they feel they have 'no choice' but to ask for assistance to end their lives.