IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY **CIV-2015-485-235**

UNDER	**The Declaratory Judgments Act 1908 and the New Zealand Bill of Rights Act 1990**
BETWEEN	**LECRETIA SEALES**
	Plaintiff
AND	**ATTORNEY-GENERAL**
	Defendant

AFFIDAVIT OF ROBERT GEORGE ON BEHALF OF THE DEFENDANT

May 2015

Judicial Officer: Justice Collins
Next Event Date: Hearing commencing 25 May 2015

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I, Robert John Dunnett George, of London, the United Kingdom, Professor and Consultant Physician in Palliative Care, solemnly and sincerely affirm:

1. I am Professor of Palliative Care at King's College, London and a Consultant in Palliative Care at Guy's and St Thomas's NHS Foundation Trust. I am also President of the Association for Palliative Medicine of Great Britain and Ireland.

2. I have been a consultant in Palliative Care Medicine since 1987. I have been responsible for or involved in the care of over 25,000 dying and suffering patients in that time from all diagnostic groups, care settings and many cultures.

3. My current clinical practice is at Guy's and St Thomas' NHS Foundation Trust, which is part of the Academic Health Sciences Centre known as King's Health Partners. I work within the local community in inner London as one of four consultant physicians in our interdisciplinary team. In particular, I am responsible for people who need palliative care in their own homes and support my colleagues in our hospitals. We offer a full spectrum of secondary and tertiary specialist palliative care. I have responsibility for tertiary advice and expert care in some rare diseases.

4. I was Clinical Lead for NHS London in Palliative and End of Life Care from 2007 to 2013.

5. I take a lead nationally on a variety of projects related to Specialist and Generalist Palliative Care.

6. I am currently Professor of Palliative Care in the Cicely Saunders Institute, Department of Palliative Care, Rehabilitation and Public Policy at King's College London. The Institute is a world leader in Palliative Care Research and Education. Mine is a Personal Distinguished Chair awarded for international eminence in clinical practice, leadership, research, teaching and innovation. Prior to that I was Senior Lecturer in the Department of Psychiatry and Behavioural Science at University College London from 1987. I am a collaborative researcher and commentator in palliative care, service modelling and delivery, and have published extensively.

7. I have trained in Medical Law and Ethics to Masters level and was senior lecturer in the Centre for Bioethics and Philosophy of Medicine at University College London from 2000-2009.

8. I have been asked to advise the United Kingdom Government on matters to do with end of life care, usually at the nexus of clinical practice, ethics and the law. For example, I was an advisor in the passage of the Mental Capacity Act 2005. Most recently I was the external expert advisor to the panel led by Baroness Julia Neuberger that examined the Liverpool Care Pathway for the Dying, a tool that has subsequently been withdrawn following the panel's report.

9. I was an expert witness to the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill in 2005 on behalf of the Association for Palliative Medicine of Great Britain and Ireland and the National Council for Palliative Care. I also made an individual submission that is annexed.[1]

10. I am a member of the Committee on Ethical Issues in Medicine of the Royal College of Physicians and was Honorary Secretary to the 2009-14.

11. I am a member of the Ethics Committee of The Association for Palliative Medicine and the National Council for Palliative Care.

12. When, in the case of *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45 the House of Lords directed the Director of Public Prosecutions (DPP) to prepare and publish an offence-specific policy setting out the circumstances that might incline him to prosecute persons who had assisted suicide, I was principal author of the submissions made to the DPP on behalf of the Royal College of Physicians and the Association for Palliative Medicine.

13. My curriculum vitæ is annexed to this affidavit as exhibit "**RG-1**".

14. I have been asked to provide my expert opinion on matters relating to this case, as follows:

    14.1 The existence or otherwise of a slippery slope of practice beyond its legal provision in legislatures where Physician Administered Euthana-

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[1] See exhibit **RG-2**.

sia (PAE) and/or Physician Assisted Suicide (PAS) are permitted and the risks and hazards to which this exposes vulnerable people;

14.2 The diverse terminology being used, and its legitimacy, in the arguments for or against changing the law on assisted suicide

15. I have read and understood the New Zealand High Court's Code of Conduct for Expert Witnesses and I agree to comply with it. I confirm that insofar as the facts stated in my report are within my own knowledge I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion within my areas of expertise.

16. I do not address directly any clinical matters in this case, but as a physician, I wish to say at the outset that over my career I have cared for hundreds of people with Ms Seales' condition and its possible sequelæ; I am familiar with the difficulties that she faces now and may encounter in the future and I have every sympathy with her in them. Whilst I take a very different view from her as to the solution, I wish her well.

Risks associated with legalising physician assisted suicide and euthanasia

17. As I wrote last year in the British Medical Journal:[2]

> Legalising medical treatment intended to end life is a momentous step: it alters the very nature of medicine at a stroke. The compelling logic is that once a doctor is mandated to end a life in that person's best interest, then anyone, as equal before the law, is entitled to make the case for a death, on the basis of notions of best interest, suffering, or a worthwhile life [and were an incapacitated patient to appear sufficiently distressed for death to be considered their best option, then to end that life as a treatment would have become the doctor's duty].
>
> Elizabeth Butler-Sloss, former president of the High Court, said, "Laws, like nation states, are more secure when their boundaries rest on natural frontiers. The law that we have rests on just such a frontier. The law is there to protect us all. We tinker with it at our peril."
>
> For me the real question is this: "Which is worse: not to kill people who want to die or to kill people who might want still to live?" In my experience it is impossible to separate those who might want to die from those who believe they ought to die and whose view is pretty well never "settled". No one can be sure that some people not now at risk will find themselves so were the law to change. A full blooded expression of autonomy includes the responsibility at times to restrain oneself on behalf

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[2] Rob George "We must not deprive dying people of the most important protection: A response to Ray Tallis" *BMJ* 2014;349:g4311.

> of another: when it comes to having our lives ended, let's keep it that way. Once this line is crossed there is no going back.

Problems associated with permitting physician assisted suicide (PAS) and physician assisted euthanasia (PAE)

18. In this section I address the future landscape that, in my opinion, a change in law to allow PAS and/or PAE would eventually produce. In summary, my view is that even on the most sympathetic reading of the data from jurisdictions that have moved to PAS and PAE, safeguards do not prevent errors and abuses and these will result in the death of some people who have not expressed a wish to die. This is what some call the "slippery slope", although it is a conflation of two distinct and invariable consequences of any change, legal or otherwise, that involves a categorical redefinition of an action.

19. The first element called the "logical slope" is in fact a single event; the second, the "procedural slope", is indeed slippery. They overlap considerably. Additional discussion is in my individual submission to the Select Committee of the House of Lords examining the Assisted Dying for the Terminally Ill Bill in 2005 annexed as "**RG-2**".

The logical slope – not necessary consequence of a categorical redefinition

20. When something changes in category the full impact and implication of that change may take time to emerge; much as opening lock-gates is a single act, the flow of water to find its new equilibrium, according to the aperture, may take considerable time but is inevitable, unstoppable and seems like a process rather than an event. Legalising PAS or PAE is like this: to redefine a criminal, lethal act as a treatment, even in an individual and circumscribed case of suffering such as Ms Seales', the aperture of which may appear insignificant and containable, ushers into medicine a whole new paradigm, which as it becomes normalised and integrated into clinical practice leads ultimately to such therapeutic killing becoming a potential treatment alongside any other. This is how things began in Holland when a judge in 1984 allowed a single euthanasia on the basis of necessity. The reasons that I regard both slopes in any jurisdiction where medicine is directly involved in PAS or PAE to be both inevitable and problematical now follow.

Freedoms becoming entitlements

21. Suicide is a freedom (a right of non-interference). Currently, few think it a good thing in itself, so society seeks to set in clear safeguards, but ultimately individuals are free to take their lives without legal consequences. Much as anyone's free aspirations cannot be limitless and will be constrained by personal resource, being able to kill oneself (as distinct from letting go of life and dying) is not possible for everyone when and how he or she might wish or demand. However, should society decide that a freedom is sufficiently good and ought to be available generally, the freedom changes category to become an entitlement (claim right), which is to be resourced and provided for all who demonstrate the need. Education and healthcare are examples.

22. Applying this to PAS, permitting someone to end another's life "in their best interest" because he or she is unable to do it reclassifies killing in some circumstances as an interest or a societal good, a mercy-killing, and makes it an entitlement, and a right to claim for anyone able to justify it. Justice then dictates that others able to mount a case, or have one made on their behalf if they are incapable, should have the same entitlement. That is how equality, equity and appropriateness work together to level the water either side of the lock.

23. PAS or PAE limited to the capable, autonomous and dying is therefore questionable morally as well as clinically. The well-meaning intent in a single case to meet someone's demand for a certain kind of death is at the same time a change in the climate of care because the lock has opened. For example, what about those with chronic debilitations whose dignity is fractured; or the distressed, demented patient unable to voice or address their suffering yet for whom death would appear (to others) a blessed relief; or the child, or the intractably mentally ill? Dying can be said to start wherever one wishes, suffering is what a person says it is, and in those who lack capacity it becomes what we *understand* to be unbearable. Perhaps even a sense that life has run its course, lost its spark and one has tired of it is now an unnecessary suffering too? The decision here cannot be about Ms Seales alone: Bolt, E. E. et al. "Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living?" *Journal of Medical Ethics*, 18 February 2015 doi 10.1136/medethics-2014-102150 (annexed to this affidavit as exhibit "**RG-3**").

24. Whilst society should afford everyone in such need the benefit of this new entitlement, there is no space for error because PAS and PAE are irreversible: it is not like the therapeutic trial of a potentially hazardous intervention that can be stopped if harm is a real and present danger, or the diagnosis revised. When done, it's done.

25. One may say that this will of course be fine if the views of individuals wanting PAS or PAE were reliable and settled, if assessments were objective and consistent, and diseases and their sequelæ predictable. However they are not. Despite the safeguards in place when the law changed in both Holland and Belgium, all of these categories of patient in paragraph 23 now have PAS or PAE performed and not all with current or prior request. All are sources of real hazards that are not isolated or exceptional. I cover the evidence in the sections below entitled "The Procedural Slippery Slope" and "Disputes over the Empirical Data from Legislatures".

Doctors' Duties of Care

26. Involving doctors paradoxically is not a safeguard, but a hazard. Why? Because medical involvement automatically classifies PAS or PAE as a treatment or clinical intervention, introduces a new potential duty of care and the subjectivity of the attending clinician's assessment.

27. Doctors are generally most concerned by evidence of distress in the incapable because of their limited ability to communicate. The burden of witness is distressing to us. We are also taught to treat on the assumption that we are dealing with the worst scenario. To take an example, in the face of an apparently distressed, inconsolable patient whose disease or symptoms are not responding to treatment immediately, the pressure to find a quick fix is considerable and sometimes overwhelming, not just for the responsible clinician but those around her – does she labour on slowly working within a person's limited capacity systematically and carefully chipping at the problem to resolve it, or use whatever she can justify as the clinician at the bedside? Currently that line is clear and all concerned are safe from a hasty or misguided and unwanted lethal act. Enter PAS or PAE, now a newly mandated treatment, but not yet permitted for the patient. The young doctor, because of some arbitrary safeguard, may well feel that the need perceived in her patient trumps what seems an il-

logical and harmful restriction in legislation that hasn't caught up. If ending the life of capable patients who appear to have indistinguishable problems is permissible, surely it is justifiable as a matter of principled duty, to use it in the parallel and, to all appearances, indistinguishable suffering by those who cannot speak for themselves? Decision-making would of course likely include asking staff and relatives their evaluation, but ultimately the decision is the doctor's and the pressure to "make it all go away" may be the trump.

28. One can both envisage and sympathise with the pressured clinician who doesn't stop at a period of controlled sedation but administers a lethal drug, reflectively justifies her decision and then finds it increasingly the most 'humane' solution for the patient, when it is in fact merely the quickest, easiest and least distressing solution to those witnessing events, including her. It will pass unnoticed that checks for reversible causes, systematic evaluations of pain, or slow and gentle conversation to calm and understand someone's internal world, however limited in access, are mysteriously seen as less and less relevant or necessary. I deal with the evidence for this below under the heading "Coercion and Other Influences".

29. As external expert advisor to Baroness Neuberger's Review of the Liverpool Care Pathway, I heard scores of case reports where gross deficiencies in care and skill were simply accepted or ignored by overworked and undertrained staff in hospitals where the culture of care had been allowed to deteriorate and patients were neglected. The most vocal opponents to changes in the law on assisted suicide, apart from the disabled, have recently come from families of such patients. The review "More Care less Pathway: a review of the Liverpool Care Pathway" is annexed to this affidavit as exhibit "**RG-4**".

Economic Pressures

30. The second source of hazard is that once a treatment enters the medical armoury it will, indeed must, be a part of legitimate evaluation of overall cost-effectiveness of available options. In Holland around 15% doctors are concerned about this: Onwuteaka-Philipsen, B.D. et al. "Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001" *Lancet* 2003;362:9381 (annexed as exhibit "**RG-5**").

31. Lastly in respect of the water settling out to a new level, it is important to appreciate that the point at which practice has been scrutinised in Holland was well into the process of PAS or PAE being a generally acceptable solution to suffering of based on the defence of necessity (which came in 1984). So evidence of changes may have settled close to or been at their minimums by the time the formal legislation was enacted in 2001 and data were being collected systematically. I say minimums, because it is entirely plausible that assisted suicide that does not meet criteria may well go unreported. Necessity is still used for cases of incapacity, neonates and children that are currently outside the law if they are reported.[3] Legislation was also passed in 2015 by the Belgian Parliament to allow PAE of children, in which the only obligation is that the child understands what is happening and the parents consent. These developments raise moral concerns: Jotkowitz, AB and Glick, S "The Groningen protocol: another perspective" *J Med Ethics* 2006;32(3):157–158 (annexed as exhibit "**RG-6**").

The Procedural Slippery Slope

32. This is concerned with the gradient and slipperiness of rules, procedures etc. It relates to two sub-areas: (1) the difficulties in assessment of the criteria that law sets in place, and with it the lack of verifiable consistency between assessors and (2) the risk of drifts (in either direction) in what is considered to be suffering, distress and dying (prognosis). The degree of additional administrative or practical burden that assessments and records place both on the assessor and the patient in terms of time, effort, and delays when both feel a decision has been made is not well tolerated by the medical profession in general. This is especially so once the incorporation of a process or procedure into custom and practice makes formalities seem onerous, pointless or irrelevant and even downright harmful after a while. Both are discernible in the literature on PAS or PAE as I detail below under "Disputes over the Empirical Data from Legislatures".

Problems to do with assessment

Prognosis and life expectancy

33. My clinical team at Guys and St Thomas' handles in the region of 1500 new referrals a year. Of those referrals a handful labelled as dying will have entirely

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[3] See exhibit **RG-7**, at p16 para 3.

curable disease. My most recent example was a schizophrenic lady with tuberculosis misdiagnosed as terminal lung cancer. The clinicians had made assumptions and did not investigate her rigorously because of her mental state.

34. The Select Committee of the House of Lords, when they examined the Assisted Dying for the Terminally Ill Bill, was told in 2004 by the Royal College of Pathologists that: [4]

> post mortem research and clinical audit studies performed in the UK, Europe, USA and many other countries consistently show around about a 30% error rate in the medically certified cause of death.

and that:

> significant errors (i.e. misdiagnosis of the terminal illness resulting in inappropriate treatment) occur in about five per cent of cases.

35. Individual prognostication, even in diseases such as cancer, is at best an estimate. Uncertainty continues even to the last days of life. I well recall my dementing father, and currently my mother, being "on the brink of dying" for years and at times expressing wishes to be dead. When death came, the clinical indices were no different from the countless "dry runs." Complex studies of comorbidities indicate that survival relates as much to toughness as anything.[5] In Oregon access to lethal drugs is meant to be confined to mentally competent adults with a prognosis of less than six months to live. After 2005 Oregon gave up reporting how many people who delayed their suicide passed the six-month survival point. Indeed, annual reports from 2000 give the maximum survival among people who delayed suicide as ranging from 10 months to 2.7 years.[6] We can define dying to start wherever we wish. As the House of Lords has said, "[Assisted dying is] either over-euphemistic or inaccurate (or

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[4] House of Lords Report 86 (Session 2004-05), Volume 2, Page 730.

[5] Goeman JJ, Le Cessie S, Baatenburg de Jong RJ, van de Geer SJ. "Predicting survival using disease history: a model combining relative survival and frailty." *Statistica Neerlandica* 2004;58:21-34.

[6] Oregon Public Health Division. "Death with Dignity Act Annual Reports" Oregon Health Authority <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

both)...we have used the term 'assisted suicide' to mean providing someone with the means to end his or her own life".[7]

36. Prognostication is unreliable and so the phrase 'assistance in dying' as an alternative to PAS or PAE becomes both meaningless and disingenuous. It certainly cannot be a special category on these facts.

Mental Capacity

37. Mental capacity is decision-specific and proportionate. The requirement of the capacity for an application for PAS, because of its finality, must be both at the top end and rest clearly on a thorough, reliable and sufficiently sensitive assessment process to be safe. This is central to any decision to support an application anywhere that takes patient safety seriously.

38. In Holland this seems not to be the case, as doctors who elect to perform PAS on incapable patients remain able successfully to claim it was necessary to manage the suffering with a lethal intervention. No one has been convicted for such action: Lewis, P and Black, I "The Effectiveness of Legal Safeguards in Jurisdictions that allow Assisted Dying" (2012, Demos, London) (annexed as exhibit "**RG-7**").

39. In Oregon for example, the Death with Dignity Act ("DWDA") requires that, where an assessing doctor has doubts about the mental capacity of an applicant or suspects that judgement-impairing depression might be present, a referral must be made for specialist psychiatric evaluation. The official Oregon Public Health Division report for 2013 shows that, for those who ended their lives by PAS in that year, such referrals were made in just 2.8 percent of cases.[8] After the first 3-4 years, when about a third of patients were referred for an opinion, per annum, this has dropped off to a level generally below 3-4 percent year on year. While this is not proof positive of failure to detect such applicants with mental incapacity or judgement-impairing depression, Ganzini et al found that three out of a sample of eighteen persons (i.e. one in six) who had died in Oregon as a result of ingesting legally-supplied lethal drugs had been suffering

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[7] House of Lords (2005) Assisted Dying for the Terminally Ill Bill first report. <www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm?>

[8] Oregon Public Health Division "Oregon's Death with Dignity Act – 2013" (2014) Oregon Health Authority <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

from clinical depression which had not been detected by *either* assessing physician and had not been referred for psychiatric evaluation. Public health data for that year showed that only 4 percent had been referred for a psychiatric opinion overall: Ganzini L, Goy ER, Dobscha SK "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" *BMJ* 2008;337:a1682 (annexed as exhibit "**RG-8**"). Ganzini concluded that "in some cases depression is missed or overlooked" and that "the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients".

40. In the same vein, Matthew Hotopf, Professor of General Hospital Psychiatry at King's College London's Institute of Psychiatry, with whom I am a research collaborator, has said "mental capacity, written down in law, looks simple. It sounds like something objective" in his oral evidence to the Commission on Assisted Dying, annexed to this affidavit as exhibit "**RG-9**". He warned that in reality such assessments are complex and not something that can be done in a one-off interview, particularly where the assessing physician or psychiatrist has had no prior experience of the applicant as a patient as may happen in some cases in Oregon. Official OPHD reports reveal the median duration of the doctor-patient relationship, across all years, was just 12 weeks (range 0-1905 days) suggesting that those who died by PAS had received lethal drugs from doctors with a very short acquaintance with them as patients.

41. From my clinical experience over 25 years responsibility for over 20,000 dying people, I agree with these comments and I do not consider, therefore, that safeguards can expunge all risk or hazards to patients with respect to mental capacity, not least because they do not seem to be followed in a small but significant number of cases.

Coercion or Other External Influence

42. Coercion is a very subtle phenomenon and can take various forms, from overt pressure and malicious encouragement, through subtle suggestion (not necessarily malicious but deriving from, for example, care fatigue), to internalised or misplaced feelings of being a burden on the family. Detecting the presence of such conditions can be difficult and depends crucially on how well the patient is known to the assessor. Here the short relationships that seem to feature in

Oregon (*supra*) are a source of risk. Where the doctor-patient relationship has been brief, it is difficult to see how a judgment that there is no coercion or influence present can rest on anything other than an absence of any obvious signs to the contrary, rather than a working knowledge of a person's family from a sustained relationship. It is surely arguable, however, given the gravity of the decisions concerned that such judgements need to rest on positive rather than negative evidence.

43. An important paper by Hicks reviewed the literature formally from a psychiatrists' point of view at the time of the House of Lords Select Committee: Hicks, MH "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors" *BMC Family Practice* 2006; 7:39 (annexed as exhibit "**RG-10**").

44. Before going any further, it is important briefly to understand two terms and concepts that appear in this paper: transference and countertransference. They are technical psychoanalytical definitions of behaviours that we all display and experience, are pervasive and powerful, yet subtle and frequently subliminal drivers of interpersonal behaviour and amplifiers of emotional currency. A simple definition for transference is the redirection of ones feelings and desires, and especially those unconsciously retained from the past towards one person, and then transferring them to someone else as though you were dealing with that first person - the classic examples is treating or reacting to someone as as though they are your partner's mother or boss. Countertransference in a sense is the mirror of that, i.e. to find yourself unaccountably responding to someone with an emotion that seems to have come from nowhere and feels not to be your own. In short, transference is your stuff and countertransference is theirs. Depending on one's social and professional skills and training, they can be simultaneously a benefit in assisting people psychologically, but potentially harmful if a clinician is unaware of displaying or experiencing them, because this may distort their judgments and assessment.

45. In this paper Hicks makes a number of important points highly relevant to the hazards of legislation, summarising her findings as follows:

> "Evidence from other countries has shown that coercion and unconscious motivations on the part of patients and doctors in the form of

> transference and countertransference contribute to the misapplication of physician-assisted suicide. Depression influences requests for hastened death in terminally ill patients, but is often under-recognized or dismissed by doctors, some of whom proceed with assisted death anyway. Psychiatric evaluations, though helpful, do not solve these problems. Safeguards that are incorporated into physician assisted suicide criteria probably decrease but do not prevent its misapplication."

46. To expand these points with respect to coercion. Dr Hicks cites four examples of coercion as cameo cases (two Dutch, two Oregonian) to illustrate that, whilst such interactions and influences are invisible to the types of reporting methods that form the body of the literature, they represent nevertheless this hazard at work actively in the lives and deaths of four real people.

47. Applying her insights to reflect on society then begins to expose why discussion and dialogue is often so fractious across the divide between the small minority who will use PAS or PAE (less than five percent internationally) and demand a change in the law and a majority either ill informed of the implications or worried that they may be vulnerable were the law to change. Many feel intimidated and sometimes even bullied when expressing concerns in open debate. It may well account also for the aggression that is expressed over language.

48. It seems to me as a clinician and citizen an unacceptable risk to mandate the few who may be disadvantaged by no legal change (recognising that they should enjoy access to state of the art specialist palliative care) in the face of what may be a comparable group being exposed to the hazard of coercion, were we able to identify them. One may of course get some glimpse by seeing that being a burden (real or perceived, one cannot know) is a significant factor identified by Oregonians both in terms of their sense of personal dignity and their desire for death.

Psychological undercurrents that influence behaviour and decision-making

49. Hicks again:

> Transference and countertransference feelings are normal and can occur in any doctor-patient relationship. When these feelings heighten around emotionally intense issues, they can exert coercive pressure on clinical decision-making with an obligatory quality that is difficult to resist. Recognition is complicated by the frequent involvement of unacceptable feelings and urges that both doctor and patient wish to deny. That specialized training is needed to systematically recognize transference-countertransference may underlie the finding that Dutch GPs are worse

> than Dutch psychiatrists at recognizing when [either] has affected a request for EAS (PAS). A survey of Dutch psychiatrists found that transference and countertransference influenced doctor-patient decision-making in 25% of all EAS requests for which psychiatric consultation was sought… [and they] influenced 19% of cases in which the request for PAS or euthanasia was granted, despite the advice of the consultant. This study demonstrates the importance of transference and countertransference as potentially distorting forces in PAS requests.

50. Dr Hicks then goes on to nuance and give texture and case examples to these claims as well as exploring the decision for assisted suicide that may in turn drive desires for death. These resonate with many of my own clinical encounters of managing difficult cases with strong personalities and feelings in which PAS or PAE often arises. They seriously undermine the robustness of transient assessments and professionals working in isolation from psychology, psychiatry and spiritual care. These are essential foundations of state of the art palliative care for they are a proven way to safeguard patients, family members and isolated clinicians.

51. A full reading of Hicks' paper and its references makes that clear and shows also that quantitative studies alone can never capture these things as necessarily the very people reporting their practice for monitoring purposes are those being influenced subconsciously. I cover this more below under the headings "Confusion over the Double Effect" and "Problems With Perceptions Of Empirical Evidence".

52. Clinicians approach patients differently according to their own attitudes to intentionally ending life hastening. In Ganzini L. *et al* "Attitudes of Oregon psychiatrists toward physician-assisted suicide" *Am J Psychiatry* 1996;153:1469-1475 (annexed as exhibit "**RG-11**"), Ganzini found that psychiatrists who opposed Measure 16 (the Bill that led to the adoption of assisted suicide within the State of Oregon) were:

> more likely to work with the patient to prevent the suicide, whereas psychiatrists who support the measure were more likely to either take no further action or support the patient in obtaining a lethal prescription.

53. Not only does the psychiatrist's stance influence the way they would manage a patient's request clinically, but also their confidence in being able to evaluate whether a psychiatric disorder was impairing the judgment of a patient requesting PAS. Only 6% were confident that they could do so within a single session.

As interesting, within the context of a long term relationship with the patient, 4% did not feel at all confident that they could make such an evaluation, 41% were somewhat confident and 54% were very confident (those who favoured measure 16 were significantly more confident in their evaluation abilities, both within one session or within a long term relationship). Further, Ganzini states in this paper, "their moral [as distinct from religious] beliefs influence how they might evaluate a patient requesting assisted suicide".

54. It is not possible to legislate for these variables, so do patients just take a chance? This represents another significant hazard that current legislation holds at bay with the clarity of a default that forbids intentional taking of life, but the temper that allows interpretation and mitigation case by case.

55. These types of judgment simply do not surface easily if at all in empirical research as clinicians are very unlikely to admit to these vulnerabilities or more troubling, simply have no awareness of their subconscious weaknesses.

56. It is clear then that the clinician's attitude, competence and training is central both to evaluation and outcome. Given that so much reliance is placed on the ability of physicians to evaluate these requests, it is worth repeating that just over half of psychiatrists (54%) felt themselves able to make an evaluation, even for a patient with whom they had a long-term relationship. The implication for physicians and consultants who are neither mental health experts, nor necessarily know patients for any extended period of time is obvious.

57. Because the majority of doctors in most countries do not regard PAS and PAE as a proper part of clinical practice, those seeking PAS may be obliged to obtain it from a minority of compliant doctors with no long-term knowledge of them as patients and, perhaps, with a general predisposition towards PAS as the preferred "treatment for death". Legalisation presented within the comforting context of a "family doctor" relationship is unreal. Holland has a state funded group of doctors willing to perform PAS and PAE and as noted already, the Oregonian data show consistently that the median time that the prescribing physician has known the patient is 12 weeks with a range between days and years.

58. Licensing an act by law does not simply codify the *status quo*: it changes the dynamic as the system responds to a former harm being reclassified as a good. Laws are not just tools for prosecuting offenders. They also signal those behaviours, which as a society we regard as unacceptable. We do not approve of aiding or abetting suicide and we go to considerable lengths to prevent or frustrate them. Irrespective of the label given, legalising assisted suicide for certain categories of people sends a public message that this usual view of suicide does not apply in the case of certain people (for example, the terminally or otherwise seriously ill) and that these lives have a different worth. All of these laws, whilst presented as measures to promote a plaintiff's autonomy, dignity etc. are in fact protections for the third party who ends the life, not the person wanting their life ended. In fact one could suggest that the *status quo*, even for those wanting assisted suicide, protects everyone by confronting the potential life-ender with the gravity of their act and their intentional moral agency in it. It affords mercy-killing the gravity it deserves – something that will be scrutinised and may have to be justified before an impartial Court. For medicine this is an essential brake.

59. Finally, similar dynamics will be seen of course in all close relationships. In discussing the risks of legalisation to vulnerable people, the application of overt pressure on individuals to seek to end their lives is likely to be uncommon - though it would be foolish to deny that it exists or that its presence can easily be detected. Much more common are the signals that relatives and others can send, albeit unconsciously, to a seriously-ill family member that he or she is becoming a burden or that family life is becoming disrupted by the illness. There is such a thing as care fatigue, and as a clinician treating patients in the final stages of their lives I have come across it in the most loving family environments. It is easy in such circumstances for seriously ill persons to feel a sense of obligation to remove themselves from the scene.

Disputes over the empirical data from legislatures

60. Here I cover briefly a small, but in my view representative selection of the empirical data that make claims that safeguards are observed and work and evidence of slippery slopes by those who do not observe them.

Dutch and Belgian Data

61. In 1984 the Dutch Supreme Court declared that doctors could assist suicide and perform active euthanasia provided it was voluntary and justified by the necessity to relieve unbearable suffering, implicitly from physical illness. In 1990 the then Attorney-General, Professor Remmelink, was appointed to oversee the first Dutch report commissioned on behalf of the Government. This reported in 1991 and is the first set of empirical data in a permissive legislature. The paper by Onwuteaka-Philipsen ("**RG-5**") summarises some selected data from the subsequent studies that continued to report in the following decade. The methods are important to describe as they influence interpretation of the sequence of data intimately. First, anonymity was guaranteed and sampling was designed to get a representative snapshot of all deaths, (purposive rather than random sampling). The lead researcher, Van der Maas, a public health doctor (not a practitioner) looked across the whole landscape of medical decisions at the end of life. This was wise as it gave some insight into how attitudes and practice may have responded broadly to the permissiveness of intentional life-ending practices beyond voluntary active euthanasia (VAE) and assisted suicide, both permissible in Holland, and as such gives some indication also about non-voluntary active euthanasia (NVAE), which at that time was not permissible. Second, it involved a retrospective questionnaire surveying doctors' memory of their practice, a death certificate survey and third, in a further purposive sample of doctors, 6 months of prospective records in which the doctors were invited to report on their management of those who died under their care in that time.

62. This gave a glimpse of how doctors might have been practicing end of life care more generally beyond the narrow definition of VAE. Returns were sufficiently significant to be valid. The report is not readily available, but its details are scrutinised and referenced in detail by Prof John Keown with particular emphasis on the robustness of safeguards and the risks and hazards that such legal changes allow: Keown J "The Dutch Experience: controlling VAE? Condoning NVAE?" In Euthanasia, Ethics and Public Policy: An Argument Against Legislation (2002, Cambridge University Press; annexed as exhibit "**RG-12**").

63. The first and second studies concluded, according to Keown,[9] that

> Decision-making by Dutch doctors was of high quality and that they were prepared to account for their conduct. [Prof Van der Maas'] lack of criticism of the widespread breaches of the guideline was remarkable and contrasts with the readiness to criticise those who identified a higher incidence of intentional life-shortening disclosed by his surveys. It will also be recalled that the Remmelink Commission placed a no less benign gloss on the data, not least on the 1,000 cases of NVAE, despite the fact that these cases drove a coach and horses through a fundamental guideline and that their revelation had initially come as a 'terrible shock' to the Commission's members.

64. Keown's assertions are all referenced and he goes on to discuss the processes through which the legislature went subsequently. Of note, he refers to a number of commentators from within Holland, and from both sides of the arguments over whether VAE should be legal, openly expressing concerns about the incidence of NVAE with quotes from a leading VAE advocate at the time, such as Leenan, Professor of Health Law: "[there was] almost total lack of control on the administration of euthanasia [in his county]"[10] and Dr Van Delden, one of the Van der Maas research team, who said "non-voluntary euthanasia cases do form a very serious problem".[11] So even those in favour of VAE and assisted suicide were clear that this was likely in the face of some patients being at risk of NVAE.

65. I put my remaining comments on more recent findings from Holland and Belgium together for brevity, and also because the majority of PAS in Belgium is in Flanders, which has very close identification with Holland.

66. The Belgian law is similar to that in Holland and indicates that the patient's request must take place without any external pressure. One would therefore expect that practitioners were diligent about second opinions, assessment of capacity etc. as I have just described.

67. Legislation is also explicit in Belgium that another independent physician must be consulted before assisted suicide is provided. However, the decision in a competent patient was discussed with another physician in only 63% of instances; 44% when this was a life-ending act without explicit request (LAW-

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[9] At 136ff.

[10] At 143.

[11] van Delden JM "Slippery slopes in flat countries - a response" *Journal of Medical Ethics* 1999;25:22-24

ER); and 48% for all end of life decisions[12]. This is discussed by Bilsen et al "Changes in medical end-of-life practices during the legalization process of euthanasia in Belgium" *Social Science and Medicine* 2007;65:803-808 (annexed as exhibit "**RG-13**").

68. Bernheim states that in "Netherlands and Belgium, where euthanasia is legal, there is no evidence of a slippery slope": Bernheim et al "Development of palliative care and legalization of euthanasia: antagonism or synergy?" *BMJ* 2008; 336(7649):864–867 (annexed as exhibit "**RG-14**"). Two references are given for this statement: one by Bilsen et al, which says "The overall incidence of drug use with the explicit intention to end the patient's life decreased from 4.4% of all deaths in 1998 to 1.8% in 2001: euthanasia from 1.1% to 0.3%, and the use of life-ending drugs without the patient's explicit request from 3.2% to 1.5%." The latter, referred to as "LAWER' 'life-ending acts without explicit request' is in Table 2 and indicates in fact that in 1998 there were 60 such cases; while in 2001 there were 56 such cases (see exhibit "**RG-13**").

69. The second reference by Van der Heide (relating to Dutch experience) says: "Of all deaths, 0.4% were the result of the ending of life without an explicit request by the patient."…"When life was ended without the explicit request of the patient [in 2005], there had been discussion about the act or a previous wish of the patient for the act in 60.0% of patients, as compared with 26.5% in 2001. In 2005, the ending of life was not discussed with patients because they were unconscious (10.4%) or incompetent owing to young age (14.4%) or because of other factors (15.3%)": Van der Heide A. et al "End-of-life practices in the Netherlands under the euthanasia act" *NEJM* 2007;356:1957-65 (annexed as exhibit "**RG-15**").

70. These references do not undermine a claim that there is a logical slope, rather they reinforce that claim. There is no criticism in what I am reflecting about the qualities or moral rectitude of the Dutch or Flemish health systems, or its society for that matter, nor the motivations of individuals. It is merely their new *status quo*, and the measurements relied on above only started well into their process of re-equilibration. There is indeed a new default and a new equilibrium because the practice of PAS and PAE in Holland is now legal. Assisted

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suicide has been applied across an increasing range of diagnoses based on the unbearability of suffering (and on the doctor's and not the patient's perception of that suffering) for near on 30 years. During this time an entire professional generation of doctors has been trained within this new clinical landscape. It is their 'normal', as will be their understandings of palliative care and what options are available in their society to mitigate suffering short of AS, the orthodoxy by their teachers of what might constitute a suffering, its unbearability etc.

71. So relatively imperceptibly also, I suggest, the interpretation of the researchers, and maybe even the way in which they have formulated and posed their questions also may have changed to reflect their norm. However, what it may also mean is that the hazard and risk to the vulnerable is taken as an acceptable reality.

72. Personally, I find even the idea of decisions by a third party to end a life because of their evaluation of its value or their perception of suffering or interests intensely disturbing, but then, I am still in the place where there is a rubicon, and I am on the side that forbids such interventions as PAS or PAE. I have not crossed that rubicon where I have performed a lethal act. These are real and present dangers and disproportionate to my mind, as a practicing clinician, to the perceived needs of a tiny minority of patients wanting assisted suicide.

The Incidence of PAS/PAE in Oregon

73. In Oregon reported legalised PAS has risen steadily since the law was changed and now stands at about 1:450 a rise of around 4.5 times since 1998. The number of persons ending their lives in this way in 2011 was four and half times the number who did so in 1998, and the upward trend shows no sign of abating, although the most recent 2013 figures are down by about 10 percent. The same is true for neighbouring Washington, which effected permissive legislation from 2009, where there was a 38 percent increase between 2010 and 2011 alone. As discussed above, the same thing happened between Holland and Flanders, the Dutch part of Belgium. PAS and PAE were legalised in 2001, where the death rate (mainly from PAE) is very much greater. In 2010 there were 3,136 cases officially notified, 93 per cent of them PAE. The 2010 total

represents an increase of 19 per cent over the total for 2009. They are now (2013) at approximately one in twenty.[13] In 2010 one in every 43 deaths in The Netherlands was from PAE or PAS, mainly the former.

74. As I pointed out above (para 35 *supra*) Oregonians expected only to survive six months may survive up to two and a half years. Consequently there are moves to relax the theoretical prognostic limit. However, it has led to an interesting alliance from both sides of the argument, but for different reasons. Protagonists fear that this will signal the beginning of a visible slippery slope, a loss of credibility as model lawmaking and they don't want to jeopardize similar legislation elsewhere. Time will tell.

75. It is plausible to argue that an initial increase is to be expected following legalisation and that much of this increase can be attributed to acts being declared which were once concealed because they are now legal. But it is also evidence of paradigm shift from which there is no escape.

Summary

76. In summary, official data on deaths from PAS and PAE are often surrounded by caveats that they reflect only declared acts. The Belgian official report for the biennium 2010-2011, for example, states that the commission compiling the report "was unable to assess the number of declared euthanasias compared with the number that actually took place" – the report defines euthanasia as acts performed with the intention of ending life. The earlier reports from the OPHD included a similar caveat. For example, the data for 2000 stated "our numbers are based on a reporting system for terminally ill patients who legally receive prescriptions for lethal medications, and do not include patients and physicians who may act outside the law". So we are in truth no better off than with current legislation other than the goalposts have been removed with legislation and the nearest meaningful identifiable and bright boundary is homicide of one sort or another.

77. These year-on-year increases in the incidence of PAS or PAE illustrate that legalisation does not simply reproduce the *status quo* in legal form but leads to an increase in these practices. Enabling laws tend to encourage the acts they

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[13] Chambaere K, Van der Stichele R, Mortier F, Cohen J, Deliens L. "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium" *NEJM* 2015;372(12):1179-80.

enable because they change the underlying social message. The criminal law exists not only to prosecute offenders but also to state clearly those acts that society considers to be unacceptable. Becoming a permissive jurisdiction sends the message that, while involving ourselves in deliberately bringing about someone's death is to be seen as criminal behaviour, in the case of certain people (in this case, those who are terminally or otherwise seriously ill) it is acceptable. The scary thing is that we give each such different names that they appear distinct when they are one and the same. I come to this in the next section.

78. Before that, one might bear in mind finally that the few jurisdictions that have legalised these practices to date have relatively small populations, and it is easy to overlook the impact that the death rates they have experienced would produce in larger jurisdictions. For example, Oregon's current death rate from PAS, if replicated in England and Wales, would produce over 1,100 legal assisted suicides annually, whereas under current (prohibitive) English law less than 20 cases are recorded annually. The death rate from PAE and PAS in the Netherlands is the equivalent of around 11,000 such deaths annually in Britain. Any jurisdiction contemplating legalisation might wish to consider how the experiences of Oregon, Washington, The Netherlands or Belgium would be replicated in their own populations.

Remaining issues

79. In this section I address a number of issues that arise in the debate about PAS and PAE. They are all to do more or less with language.

Definitions of lethal acts such as Rational Suicide

80. I have read the affidavit of Richard Glynn Owens and have the following comments in relation to the distinction drawn between suicide and "rational decisions to die" – a term which Professor Owens denotes "with or without assistance from others".

81. The concept of rational suicide and its euphemism in the dying of a 'rational desire for death', combined with 'aid in that dying', sits mostly in the psychological literature where it is deployed as part of apologetics for the legalisation of assisted suicide and euthanasia. It occurs also in philosophical discourse where it is subject to forensic scrutiny that is directed largely at testing its in-

ternal coherence and viability as an idea at all. Whilst the Professor Owens affidavit shares the RDD polemic, the references in my affidavit almost all use the traditional and more factual vocabulary familiar to front line medicine. Indeed, most clinicians will be puzzled by phrases such as "aid in dying" for the reasons given above under "Prognosis and life expectancy"; it is so ambiguous as to be worthless in a practical rather than political sense and in palliative care at least a 'rational desire for death' is something that one encounters transiently and repeatedly in most people as their feelings and beliefs iterate with the ebb and flow of symptoms as they near life's end. We see it as something to engage and not to deify.

82. In reading Prof Owens' comments at 12(b) of his affidavit, I was surprised to see the statement "the psychologist's role in a potential suicide case is to reveal that the person's problems are not insurmountable; that is not an appropriate response in the RDD case." I disagree with this utterly. Expert palliative care sees enormous value in exploring potentials for recasting with them a dying person's view of self to explore other perspectives and realities with which to transcend an existing state of affairs that the person finds unacceptable or a source of suffering. It seems to me that his position is taking a narrow and particular cognitive view of what might be a complex emotional and spiritual matrix in need of more sophisticated engagement.

83. I wish also to comment on 12(d). I do not recognise the description of those wishing to die and not having assisted suicide as thereby suffering terribly as they die from their disease, let go of life or forgo food and drink. It simply is not my experience both in terms of how quicky or slowly they die or their experience as they do. Let's not forget that ceasing to eat and drink for example is entailed in the natural dying process and may in reality precede death by days and even weeks with no distress. Approaching such situations, of which I have seen many hundreds, and asking what is keeping a person alive when their disease is killing them and their expressed wish is death, opens a very different perspective and landscape to address unfinished tasks, unresolved relationships and seek personal resolution in order that the person can let go of life and die comfortably with the necessary support and care. It is usually exceptionally dignified and measured as they withdraw from the world, stop eating and drinking as they wish, and having the necessary mouth and other personal care

to remain comfortable. I gave concrete examples in my evidence to the Select Committee of the House of Lords (exhibit **RG-2**).

84. The best palliative and end of life care does not in my experience need lethal options. I can look after someone as they die with a panoply of medications and techniques. However, I am also part of a team with all the necessary skills to address complex disease, complex people and complex families. Societies need this level of care at the very least before they go through the wide gate of PAS and PAE. A person may of course want a definitive act, but that doesn't make it either necessary or right for the following reasons: the existence of an state of affairs such as a rational desire to die is no more a justification for its assuagement than a rational desire for the best of everything is a justification to demand and expect that one gets it. We do not live in autonomous nuclear universes of unlimited self-determination: that is an unreal caricature. Rounded autonomy recognizes and respects others' needs, limits and preservation as equal and sometimes the expression of one's self determination where necessary, prudent or civil may be to deploy it in self-restraint. It is my opinion that PAS is just such a case and the evidence I have presented bears this out.

85. It is my experience in the overwhelming majority of people who really want to discuss and consider the option of suicide discover to their great relief that letting go is as much an expression of control as suicide. That is the real liberation, which they may and generally do grab and relish.

Aid in Dying is a meaningless phrase

86. Assisting a person in their suicide is categorically different from suicide – it is not just a practical matter of helping someone express their autonomy through a neutral agency.

87. First, such assistance introduces a second moral agent who must make a moral judgment herself whether or not to act. There needs to be moral agreement to proceed. The idea that prescribing medication or setting up the means for someone to kill herself is just a neutral act does not make any sense. Second, to ignore the sensibilities of that actor or expect them to act against her wishes or with reluctance is a violation both of personal and professional autonomy and

may even expose them to personal moral hazard along the lines to which Hicks refers (see exhibit "**RG-10**").

The robustness of conscientious objection

88. Currently all legislation permitting PAS and PAE includes a conscience clause. However, is that sustainable? First, there is a growing assertion amongst philosophers that to agree to be a professional and then to say that there are aspects of the profession one is not willing to countenance is untenable. This was thrown into sharp relief recently in the debate beginning in Canada over PAS.[14] Whilst the protagonist of removing conscience clauses takes an extreme position, he nevertheless points out that to object to involvement in an aspect of one's known professional duty is unlikely to hold water for very much longer. We saw it at the end of the last century worked through in people objecting to care for people with HIV in one way – an absolute clarity as to duty, and in another through the outworking of abortion legislation, with the selecting out of people from a specialty. This piece has engendered strong reactions but nonetheless demonstrates the way in which law not only reflects society that starts also to sculpt it.

89. Second, in England, new legislation going through Parliament on care entitlements, according to our defence unions, exposes in theory anyone refusing to administer, even on conscience grounds, a recognised treatment should they experience harm whilst awaiting a referral to a compliant colleague, to a charge of breach of duty.

PAS is not categorically different from PAE. It is a difference of degree driven only by practical and pragmatic considerations

90. Legislation modelling itself on Oregon, which only permits PAS, rests on distinguishing PAS from PAE and implying that they are morally distinct. I suggest that this cannot be true as the difference between actions is not just practical, but begins by being moral, and particularly so when done as part of professional practice.

91. The moral distinction between actions lies in the difference in intent. I see no difference ethically between prescribing an antibiotic and administering it in an

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[14] Michael Cooke "Canadian bioethicist attacks conscientious objection" (18 April 2015) BioEdge <http://www.bioedge.org/>.

injection. What counts is the decision that the infection ought to be treated, not how. Why should it be any different in making lethal decisions? Should ending a life become legal, it is clinical common sense that there would be no arbitrary line between means of delivery. Early Dutch studies reported that doctors preferred euthanasia to assisted suicide to ensure that death was achieved effectively.[15] The ratio of cases of euthanasia to those of assisted suicide rose from 141:18 in 1990 to 475:21 in 2010.[16]

Confusion over and misuse of the Double Effect

92. The Doctrine of Double Effect (DDE) in medicine is well known: that the risk of a potential, unintended consequence of treatment is justified if the purpose and intention of that treatment is to benefit the patient, the situation sufficiently grave to merit the risk and the desired benefit isn't achieved through the bad effect. All treatments fit into this scheme including common interventions such as insulin for diabetes (which is lethal even in modest overdose). Yet, despite the safety of opioids when prescribed properly, DDE is linked primarily with morphine prescribing in the dying. I deal with this in detail in the attached paper: George R, Regnard C. "Lethal opioids or dangerous prescribers?" *Palliative Med* 2007;21(2):77-80 (annexed as exhibit "**RG-16**").

93. In studies purporting to have questioned practitioners about their practice in care of people whilst they die, this confusion not only leads to wrong and leading questions in study methodology, but to practitioners being caught in rational double binds in which they assume that they are killing people all the time with opioids and sedatives, whether they want to or not. This may well be a significant influence, as the authors infer in their conclusions, of the ways in which GPs in New Zealand perceived intentionality and reported their practice in 2004.[17]

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[15] Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der Wal G. "Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands [comment]." *NEJM* 2000;342:551-6.

[16] Delden JJM, van der Heide A. "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey." *Lancet* 2012;380:908-15.

[17] Kay Mitchell, Glynn Owens "End of life decision-making by New Zealand general practitioners: a national survey" *NZMJ* 2004;117(1196):1-11.

New view of utility and economics

94. As unpalatable as it may feel, cost and cost effectiveness looms large in all societies now. Should PAS or PAE be permitted, as in all the explicitly permissive legislatures, it will be embedded in healthcare unless clear steps are taken to insulate care from killing. As such, PAS therefore enters irrefutably into the cauldron of general health care economics, and rightly so. PAS is quick, definitive and very cheap. Not surprisingly, therefore, reports are creeping into the literature of cases in which expensive treatments such as chemotherapy are being denied funding, but PAS has been offered. More tangibly, though the Lancet review of Dutch practice in 2003 reports around 1:15 doctors worrying about pressures being brought to bear on them for economic reasons. Finally, there is the inevitable hazard to our ageing population as health and social costs rise.

Physician involvement

95. Legalised assisted suicide is usually framed as *physician*-assisted suicide (PAS), it brings into play another question - namely, whether such practices can be considered a proper part of clinical care and how, in the face of opposition from the majority of doctors, they can be carried out safely. The offence-specific policy issued in the English and Welsh Jurisdiction by the DPP setting out the circumstances which might incline her to prosecute or not reflects this in how it will deal with clinicians who involve themselves directly in PAS.

96. Most Professional Associations around the world, along with the Royal Colleges in the UK in recent surveys show clearly that doctors believe that legislation should not involve medicine in implementing assisted suicides but that it should sit, if anywhere, with the courts and appointed executives as the safest place for all concerned.

97. That is not to say, of course, that addressing and engaging with those with the desire for death is to fall outside modern medical practice - quite the contrary. Clinicians with any bedside practice should be encouraged and trained specifically to have these conversations, to know at the very least what options are available to mitigate suffering and symptoms and how to access such services. This is the domain of specialist palliative care, something that is not available generally at the requisite levels of sophistication in the jurisdictions that permit

PAS. For example, in my opinion although all would claim that they have palliative care, few have the complex interdisciplinary teams and services that such practice in the hard cases of PAS requests and unbearable suffering demands. Simply to have on record that someone has been assessed or referred to palliative care is meaningless without understanding what that means in that locality.

Problems with perceptions of empirical evidence in areas of value judgments: the matter of vulnerable groups

98. Research across the board in PAS and PAE is fragile for no other reason than it relies almost entirely on voluntary reports by individuals of their actions and opinions or the results of qualitative and semi-quantitative research such as questionnaires that rest in turn upon the premisses and values of the researches themselves. Researchers are not utterly immune to the difficulties that Hicks identifies in clinicians.

99. In 2011, with Professor Ilora Finlay, I published a critical analysis of claim that there is no empirical evidence that, where PAS has been legalised, vulnerable groups of people are at heightened risk: Finlay IG and George R "Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups: another perspective on Oregon's data" *J Med Ethics* 2011;37:171-174 (annexed as exhibit "**RG-17**").

100. Battin *et al* stated, in their 2007 research,[18] that their examination of the impact of PAS on vulnerable groups showed that there was "no evidence of heightened risk" to elderly people from legalisation of PAS. This conclusion rested on a definition of "elderly" as comprising persons aged 85 or over. Their report showed that this age group accounted for 10% of deaths from PAS over the years 1998 to 2006, whereas 32% of such deaths had occurred among persons aged 18-64. From this they drew the conclusion that "persons aged 18-64 years were over three times more likely than those over 85 years to receive assisted dying". While this conclusion was correct so far as it went, their report also showed that 58% of deaths from PAS had occurred among persons aged between 65 and 84, an age group that most people would regard as falling within the ambit of the term "elderly". This large cohort of PAS deaths was, however, ignored in drawing conclusions as to the relative incidence of PAS

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[18] Battin MP, van der Heide A, Ganzini L et al "Legal-physician-assisted dying in Oregon and The Netherlands: evidence concerning the impact on patients in 'vulnerable' groups" *Journal of Medical Ethics* 2007;33(10):591-597.

among the elderly and among younger people. If it had been included (as surely it needed to be), their research would have shown that more than twice as many deaths from PAS (68%) had occurred among elderly people as among younger persons (32%). While this latter finding does not mean that elderly people are necessarily at heightened risk from PAS, the authors' finding cannot claim credibly that there is "no evidence of heightened risk". What I would agree with is that the significance of this is not as yet clear, but it would be a very thin justification for a major reclassification of the intentional taking of life.

101. Second, and in the same vein, in our 2011 critique we also questioned the conclusions "none of the 292 patients who died under the [Oregon Death with Dignity Act between 1998 and 2006] were determined to have a mental illness influencing their decision" and that "there is no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the [Act]".

102. Our critique drew attention to a cross-sectional survey of the prevalence of depression among patients seeking PAS by Ganzini (exhibit "**RG-8**").

~~103.~~ They had examined 58 patients, 18 of whom had received a prescription for lethal drugs. Three of these latter met the researchers' criteria for depression. "No evidence of heightened risk" to depressed applicants for PAS is wrong. Ganzini's conclusion published within a year stated "the current practice of the Death with Dignity Act may not adequately protect all mentally ill patients".

Conclusions

104. Licensing doctors to supply lethal drugs to some of their patients would represent a major change to the criminal law. Before embarking on such a course it is necessary to be satisfied that the law as it stands is not fit for purpose; and, if that should be the case, that what would be put in its place would be better - and, above all, safer. I cannot speak authoritatively for the situation in New Zealand. In the UK, however, cases of assisted suicide are rare. On the other hand, where assisted suicide has been legalised, the incidence of such deaths has risen significantly.

105. I have considered the risks and hazards for society as a whole, and the vulnerable in particular. In my view that they are too great, particularly because, since

they are all subjective and as much specific to the assessor as the patient, they are not in my view amenable to proper scrutiny of legislative safeguards.

106. As a clinician and citizen, I believe that the prospect of a legislative change around care of the suffering and dying that will place people of any kind in mortal danger is deeply troubling. This is because I am simply unable to see any life no matter how compromised as worthless, or from the thousands of people I have worked with as they have transcended their sufferings to pronounce any suffering as insurmountable or refractory. I have been proven wrong too many times and safe and non-lethal techniques are at our disposal to give relief or respite no matter how severe the distress. I cannot therefore countenance ending a life in the sure knowledge that some would have had more living to do. None of the safeguards currently in place for example in Oregon, Holland or Belgium can or do remove risk to an individual entirely. That is generally agreed, and speaking for myself is insurmountable, although I recognise that such balances are a matter for societies individually to make.

107. Overall, based on my review of the literature and my clinical experience, it is my opinion that it is impossible to develop a permissive legislative environment, and especially when involving doctors, without exposing at least some patients to the fatal risks and hazards of assisted suicide when they either do not want it or may be incapable of giving a free and informed view. In particular, concerning safeguards in permissive jurisdictions, in my view the risks and hazards of decriminalising assisted suicide are substantial and insurmountable. In summary, my concerns are as follows:

107.1 Confining legally permitted assisted suicide to the terminally ill is unsustainable;

107.2 Clinical assessments are potentially very unreliable;

107.3 The risks of vulnerable people (including health care professionals) to coercion is high and cannot be monitored adequately;

107.4 Reporting in these permissive jurisdictions depends universally on declared acts and therefore at best involves estimates of minimum numbers of cases in any category and risks that breaches of the Law never come to light.

108. Finally there is increasing concern that the incidence and scope of assisted suicide and euthanasia as reported does not eliminate the probability that the incidence of this practice, including on those unable to given consent, continues to rise in those countries that have permitted PAS, and PAE in particular. Even where it is lawful, concern has and does remain with a significant number of clinicians that the unwilling person will be unprotected.

AFFIRMED)
at London this day of)
May 2015)
before me:)

Robert John Dunnett George

A person who is duly authorised to administer oaths by the law of England and Wales