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 RICHARD GLYNN OWENS
AFFIRMED 24 APRIL 2015

RUSSELL McVEAGH

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I, RICHARD GLYNN OWENS, Professor of Psychology, of Auckland, solemnly and sincerely affirm:

Introduction

1. I am a Professor of Psychology at the University of Auckland, specialising in the psychology of end of life care.

2. I obtained my bachelor's degree in psychology in 1974 at Brunel University, my doctoral degree in 1977 at the University of Oxford and my Diploma in Clinical Psychology in from the British Psychological Society. I have been a practicing psychologist for over 40 years, and have held a variety of positions including Director of Clinical Psychology Training at the University of Liverpool, Professor of Health Studies at the University of Wales, Bangor, and Professor of Forensic Clinical Psychology at Bangor University.

3. I have conducted and published research in a wide range of areas within psychology including forensic psychology, health psychology and the psychology of death and dying. I have provided clinical care to dying patients in a number of hospices and hospitals in the UK and New Zealand, and am a former member of the Board of Trustees of the South Auckland Hospice. I am a former President of New Zealand's Independent Forensic Practitioners Institute. A copy of my complete Curriculum Vitae is annexed as exhibit "**RGO1**".

4. I have been asked to give evidence concerning:

   (a) the efficacy of palliative psychology in end of life care;

   (b) the distinction between suicide and aid in dying;

   (c) premature death arising from terminal illness;

   (d) assessing the competence of people in Lecretia's circumstances; and

   (e) decision-making where aid in dying is available.

5. To the extent I express opinions in this affidavit, I confirm that these matters are within my areas of expertise and experience. I confirm that I have read the High Court Code of Conduct for Expert Witnesses as set out in schedule 4 of the High Court Rules. I agree to comply with that Code.

Efficacy of palliative psychology

6. I have over 30 years experience working in the clinical practice of palliative psychology. I have worked with dying patients in the community, in hospices and in hospitals, in New Zealand and the United Kingdom. I have provided education in end-of-life care to a variety of professional groups including doctors, nurses and psychologists in New Zealand, China and the United Kingdom.

7. Palliative psychology aims to assist patients with the psychological consequences of a terminal diagnosis. While every patient is different,

SA GO

end of life patients frequently experience anxiety, depression, loneliness and feelings of frustration. My work as a clinical psychologist has been to help patients, to whatever extent possible, to come to terms with their diagnosis and to increase their quality of life during the period before their death. This may include helping with intractable pain, sleep disturbance and nightmares and emotional problems such as fear, anxiety and depression.

8. I have occasionally cared for patients diagnosed with oligoastrocytoma. The psychological symptoms experienced by these patients can be highly varied and person specific, but often include headaches, seizures, perceptual and motor difficulties and (of course) symptoms such as those referred to in paragraph 7 above, which tend to cut across diagnostic categories.

9. I have also read the affidavit of Lecretia Seales. She appears to be a person who is driven, organised and who has sought success in all areas of her life. In short, she presents as a person with strong perfectionistic tendencies. The study of perfectionism is a substantial part of my work, and I have published several peer-reviewed articles on both theoretical and empirical aspects of perfectionism. I am the author of a widely-used measure of this trait. In my experience, people with these traits frequently find the effects of an illness like Lecretia's particularly intolerable because the loss of autonomy and inability to manage their lives is directly contrary to the things they value.

10. In Lecretia's current circumstances, where autonomy and self-sufficiency are both highly valued and likely to be increasingly affected, and the patient is only expected to live for a short period of time, palliative psychology is likely to be ineffective. It may, in fact, exacerbate the psychological impacts of the condition. This is because a person with Lecretia's character traits is likely to find the cognitive therapy process frustrating and upsetting if the tumour, through the kinds of symptoms discussed above at paragraph 8 (such as headaches and difficulty concentrating or maintaining focus), interferes with her ability to engage properly with the therapy. The efficacy of such therapy is also greatly reduced where the timeframe is short. Accordingly, I believe that palliative care is likely to be of little benefit to Lecretia in easing her psychological and emotional suffering from this point onwards.

Distinction between suicide and rational decisions to die

11. I have read the brief of amicus of the New Mexico Psychological Association filed in the matter of *Morris v Brandenberg* (annexed as exhibit "**RGO2**"), and the transcript of the evidence of Dr Pollack filed in the same case, annexed as exhibit "**RGO3**". The distinction those materials draw between suicide resulting from impaired thinking ("suicide"), and a rational decision to end one's own life (either with or without assistance from others) by a person suffering from a terminal illness ("rational decisions to die", or "**RDD**") accords with my academic knowledge and clinical experience. The distinction between these two concepts has also been accepted in other academic literature, including in a valuable 2014 discussion in the prestigious Journal of the American Medical Association (annexed as exhibit "**RGO4**").

SG GO

12. From a psychological perspective, a number of features distinguish suicide from RDD. These include:

    (a) The thinking that leads to thoughts about killing oneself is different. Suicide results from impaired thinking. By contrast, RDD are the result of a rational process by a mentally competent person.

    (b) The future prospects in each case are relevantly different. Suicide arises where, as a result of impaired thinking, a person does not understand that his or her problems are treatable, and that he or she can overcome suicidal feelings and go on to enjoy a long life. In other words, there is a failure to rationally identify, assess and balance the available options and consequences. Further, that failure is transient in nature. RDD are different: they occur where a person understands accurately that he or she is dying from an incurable illness. 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. Of course, depending on the patient, a psychologist can assist a person who has made a request for aid in dying to think about whether he or she actually wants to carry out such a request. But that assistance would not be premised on the patient suffering from a cognitive disorder; rather it would be based on talking with the patient about what matters most to them, and whether some or all of their fears or anxieties can be addressed through means such as palliative care. The approach outlined here would apply equally - from a treatment perspective - to people suffering a terminal illness but still having the physical capacity to end their life without assistance from another person.

    (c) Suicide is irrational, often impulsive and emotionally-driven: the evidence shows that removing opportunities for persons to take their lives (for example, by putting railings on bridges) dramatically decreases the incidence of suicide (see, for example, the 2007 article of Bennewith, Nowers and Gunnell in the British Journal of Psychiatry annexed as exhibit "**RGO5**"). RDD, on the other hand, typically reflect an autonomous choice made over a period of time by a person with rational control, often after consultation with his or her family.

    (d) Where a person who wishes to make a RDD is prevented from doing so, they often live only a short while longer and suffer terribly during that time, both physically and psychologically. By contrast, people who are prevented from successfully committing suicide often go on to enjoy long and happy lives, glad that they did not die.

13. In New Zealand the number of cases where RDD has been known to occur *with the involvement of family members* is, to my knowledge, low. That is because many people diagnosed with life-ending illnesses feel that they cannot include family members in that decision, and certainly not in carrying out the decision, due to legal concerns. There have, however, been a limited number of cases where family members have been involved in RDD, and have been able to describe their experience.

In those New Zealand cases (albeit there are few of them) of RDD where family members have been included in the process of decision-making, and/or have been present when death occurs (not, obviously, if the deaths are violent, but rather if medication is taken) the families are often able to deal effectively with grief. The process of consultation in the lead up to RDD (and in those cases where family are present, the presence at the death) can bring families together and allow them to feel they can support the patient.

14. I contrast this with the position of families of suicide victims. I have worked with a number of families of suicide victims. The effect on those families is very different from that described in paragraph 13. Family members of suicide victims are often emotionally traumatised. They often feel abandoned, angry and that they have failed their family member. Similar effects are felt by family members who had an inkling that their loved one might have made a RDD, but were not involved in the decision-making process (because of legal uncertainty I have noted above), and felt they could not be present at death (because of the same uncertainty).

Premature death arising from terminal illness

15. Through my professional experience, I am aware of patients suffering from terminal illness who have taken their own lives earlier and/or by more painful means than would be necessary, if aid in dying were available. For example, many years ago I had the opportunity to discuss with a man named Andrew Short his experiences around his wife's death. Because no assistance was available she and he jointly decided that she would take no further food or fluids. Her death was prolonged and distressing to both. Mr Short went to the lengths of recording the sounds of distress being made by his wife Kit. I still use this recording, with his permission, in my teaching.

Assessing competence to consent to aid in dying

16. The distinction between suicide and aid in dying discussed above reflects that although persons suffering from terminal illness are likely to suffer psychological symptoms such as fear, anger and low mood, this does not mean they are not competent to make decisions, including as to refusing life sustaining treatment or ending their suffering through aid in dying.

17. In particular, a distinction should be drawn between anxiety or depressive symptoms of terminal illness (ie low mood), which do not affect a person's competence to make decisions, and clinical depression or other serious mental illness. While it is possible for those with terminal diagnoses to have conditions that affect mental competence, it is not the norm.

18. Clinical psychologists and doctors are regularly required to assess patients' competence to make decisions in the course of their day to day practice. From a clinical perspective, depressive symptoms of terminal illness and clinical depression affecting competence look completely different.

Decision-making where aid in dying is available

19. Research shows that in countries where aid in dying is available, many end of life patients do not ultimately exercise that option. For example, in

Oregon, between its enactment in late 1997 and 2014, only 64.37% (859 of 1,327) of patients who were prescribed life-ending drugs under the Death With Dignity Act 1997 ended their lives by taking them.[1] In 2014, only 60.6 % of patients who obtained the drugs ingested them.[2] These statistics are outlined in the exhibit annexed as "**RGO6**". This shows that at the time a patient is prescribed a life-ending drug, it is by no means certain that he or she will in fact exercise the option to take the drug.

20. However, having the ability to control how and when one will (through possession of a physician-prescribed life-ending drug) die can of itself provide comfort and lessen a patient's psychological and emotional suffering. I have read and agree with the oral evidence of Aja Riggs and David Pollack in *Morris v Brandenburg* at pages 63 - 64 and 94 - 96. The transcript of that evidence is annexed as exhibits "**RGO7**" and "RGO3" (previously cited above). In summary, the option of aid in dying:

(a) may give a patient 'peace of mind' which lessens anxiety and psychological suffering at end of life;

(b) ensures that a patient feels involved in choices at the end of their life, which can increase their quality of life;

(c) may, for many individuals, extend the period of life they experience because having been given the ability to control the end of their lives, they choose not to die prematurely and instead wait until such late point as they choose to ingest the life-ending drug or choose not to ingest the drug at all; and

(d) does not mean that a patient will choose to use it, if alternatives may still result in a "good quality death". I would expect the alternatives to be assessed and evaluated by the patient, and the care team around the patient, on an ongoing basis.

AFFIRMED at Auckland this 24th day of April 2015 before me:

~~A solicitor of the High Court of New Zealand~~
An enrolled solicitor of the
High Court of New Zealand
Samuel Robert Gapes
Sworn at Auckland

Richard Glynn Owens

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[1] http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf.

[2] http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf.

"RGO1"

Curriculum Vitae
Richard Glynn Owens

This is the annexure marked **"RGO1"** referred to in the affidavit of **Richard Glynn Owens** affirmed at Auckland this 24/04/15 day of April 2015 before me

Signature ....

A Solicitor of The High Court of New Zealand Samuel Robert Gapes
(Solicitor to sign in part on Exhibit)

Summary

Professor of Psychology, former Professor of Health Studies and Professor of Forensic Clinical Psychology
UK citizen, resident in New Zealand

Experience in Health, Clinical, Forensic and Sports Psychology

Graduate of Brunel University with BTech(Hons) and Oxford University with DPhil. Holder of Diploma in Clinical Psychology

Over thirty years' experience of teaching to a wide range of students at graduate and undergraduate level

Sole supervisor of five successful PhD projects and primary supervisor of several others

Around 100 published works including eight books and over 60 journal articles

Around $NZ1,850 ,000 in research funding.

Experience of industry, courts, media etc.

Active researcher in the fields of Health Psychology, Research Methodology and Ethics.

Part 1: Personal Information

Name: Richard Glynn Owens

Place of Birth: Oldham, UK

Date of Birth: 20th July 1950

Citizenship: British/European
(Holder of Permanent Residence status and indefinite returning resident's visa, New Zealand)

Address (wk)
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g.owens@xtra.co.nz

Education (Academic)
1970-1974; Brunel University, Uxbridge, Middlesex
Bachelor of Technology (Hons), 1st Class, Psychology
Prize for best Finals student.
1974-1977; Wolfson College, Oxford
DPhil (Clinical Medicine)
Thesis title; "The Conjoint Schedule in Human Operant Behaviour"

During the years 1990-1995 I was also enrolled with the Open University studying for the degree of BSc in Mathematics; my move to New Zealand necessitated my discontinuing my studies shortly after successful completion of my first Third level paper (Pure Mathematics)

Education (Professional)
Diploma in Clinical Psychology
British Psychological Society 1979.

Accredited as a Sports Psychologist (Clinical) by the British Association of Sports and Exercise Sciences, UK.

Summary:

I am a UK citizen and NZ permanent resident, and currently Professor of Psychology at the University of Auckland, with qualifications in experimental, clinical and sports psychology.

Education

Secondary

1961-1967	William Hulme's Grammar School, Manchester, UK
1967-1968	Paddington College, London

Universities

1970-1974	Brunel University, Uxbridge, Middlesex
1974-1977	University of Oxford (Wolfson College)
1990-1995	The Open University

Educational qualifications, distinctions etc

1974	Bachelor of Technology (Hons) Psychology, 1st Class Awarded Departmental Prize for best finals student
1977	Doctor of Philosophy, Faculty of Clinical Medicine, University of Oxford.

Other professional qualifications

1978	Diploma in Clinical Psychology, British Psychological Society
1990	Accredited Sports Psychologist (Clinical), British Association of Sport and Exercise Sciences
1998	Registered with NZ Psychologists' Board: Registration no. 90-02036

Summary/Comments

Initially my education centred on experimental psychology, which led to my first degree and my DPhil. Whilst conducting my research for the DPhil I also undertook a part-time clinical training, which led to my qualifying in 1979. Since that time I have always maintained a clinical caseload. Similarly my work with sportspeople at all levels together with my published research led in 1990 to my being accredited by BASES as a sports psychologist (clinical).

My studies with the Open University were prematurely ended when I left the UK to work in New Zealand. Nevertheless they remained of considerable value, not only enhancing my mathematical skills but also reminding me of the pressures and difficulties of being an undergraduate with assignment deadlines to meet and examinations to prepare for – experiences which usefully inform my own teaching.

Theses

1971	*"The Jesness Inventory, Eysenck's PQ, and young prisoners on remand"* Prepared for Brunel University and the Chief Psychologist's Office, Prison Department, Home Office
1974	*"Aspects of Behaviour Modification"* Undergraduate Thesis, Brunel University.
1977	*"The conjoint schedule in human operant behaviour; its establishment, maintenance and control"* DPhil thesis, University of Oxford

Comment

It will be apparent from the various theses that I have completed that I come from a broadly experimental background, drawing on both large-scale and small-N research designs. In later years I have extended these to incorporate various forms of qualitative research (see "Publications" later)

Affiliations

1970	British Psychological Society (originally student subscriber, now Associate Fellow)
1976	Member of Mathematical and Statistical Psychology Section, BPS
1979	Member of Division of Clinical Psychology, BPS
1980	Member of Division of Criminological and Legal Psychology, BPS
1981	Founder member, Counselling Psychology Section, BPS
1985	Member, British Psychosocial Oncology Group
1986	Founder member, Health Psychology Section, BPS
1988	Member, British Association of Sports Sciences
1987	Member, European Health Psychology Society
1992	Foreign Affiliate, American Psychological Association
1995	Founder member, New Zealand Health Psychology Society
2000	NZ Membership coordinator, Australasian Society for Health and Behavioural Medicine
2005	Founder member, Independent Forensic Practitioners Institute

Comment

Throughout my career I have maintained active links with those organisations which relate closely to my professional and academic interests.

Employment Record

1967-1969	Student Medical Laboratory Science Officer, North Manchester Hospitals
1969-1970	Student/Junior Medical Laboratory Science Officer, Barnet General Hospital
Apr-Oct 1971	Student Assistant, UK Atomic Energy Authority
Apr-Oct 1972	Student Psychologist, HM Remand Centre, Risley
Apr-Oct 1973	Nursing Assistant, Moss Side Hospital, Liverpool

Posts 1971-1973 were completed as part of Brunel University's sandwich course in Psychology

1974-1977	Medical Research Council Research Student, Department of Psychiatry, University of Oxford
1975-1977	Probationary Clinical Psychologist, Oxfordshire Regional Health Authority (Honorary Contract)
1977-1979	Senior Psychologist, Prison Department, Home Office
1977-1979	Probationer Clinical Psychologist, St James' Hospital, Portsmouth (Honorary Contract)
1979-1980	Senior Clinical Psychologist, Moss Side Hospital, Liverpool
1979-1983	Tutor in Research Methods (Undergraduate and Postgraduate), the Open University (Part-time)
1980-1988	Lecturer in Clinical Psychology, Liverpool University
Jan-Sept 1989	Lecturer in Psychology, University of Wales, Bangor
1989-1991	Senior Lecturer (Clinical) in Clinical Psychology/Director of Clinical Psychology Training Course, University of Liverpool
1980-1991	Regional Specialist in Clinical Psychology, Mersey Regional Health Authority (Honorary contract)
1992-1995	Professor of Health Studies, University of Wales
1995-present	Professor of Psychology, University of Auckland (present post)

2003-2005 Professor of Forensic Clinical Psychology, University of Wales (post held during two-year period of unpaid leave from University of Auckland; held concurrently with post of Consultant Clinical Psychologist, North Wales Regional Forensic Service).

Summary/comment

My previous posts have provided me with a wealth of valuable experience, including clinical, health and forensic psychology and the teaching of research methodology. My more recent Professorial posts have given me the opportunity to demonstrate and exploit my leadership skills.

Teaching experience

Current Responsible for one Master's paper (taught twice/year), jointly responsible for one Stage II and one Stage III paper, approximately 1/3 of a Stage I paper (taught three times/year) and contributions to several other undergraduate and postgraduate papers including Sport and Exercise Psychology, Applied Behaviour Analysis and Clinical Psychology.

The only paper I teach exclusively (Death and Dying, Master's level) was rated 6.9 on a 0-7 scale by students on "amount learned".

External On a voluntary basis I give lectures and talks on issues related to Death and Dying to a number of charitable groups, in particular St Joseph's hospice and South Auckland Hospice.

Workshops Periodically I run workshops dealing with a number of issues primarily relating to professional aspects of clinical psychology. Topics include:

Breaking bad news
Dying and sexuality
Pain management
Treatment of sleep disturbance and nightmares
Stress management
Dealing with difficult people
Effective teaching

Previous My previous posts have involved a considerable amount of formal teaching to a wide range of undergraduate and postgraduate students. Topics taught have included;

Introductory Psychology
Psychology and General Medicine
Formulation of clinical problems
Research Design
Sports Psychology
Human sexuality
Psychological assessment & Psychometrics
Applied Behaviour Analysis
Forensic Psychology
Dealing with difficult people

Students on such courses would come from a variety of backgrounds. Groups taught have included;

Undergraduate Psychology students
Undergraduate Medical Students
Undergraduate nursing students
Postgraduate Clinical Psychology trainees
Postgraduate trainees in Psychiatry
Postgraduate nursing students
Undergraduate students in Physical Education/Movement Science
Undergraduates on modular degree programmes (Open University)
Postgraduate Social Work students
Postgraduates in Psychology and Education (Open University)

In addition I have supervised a large number of undergraduate and postgraduate research theses. These include the exclusive supervision of three part-time and one full-time PhD students whilst at Liverpool; all but one were awarded their PhD's, the remaining (part-time) student discontinuing her studies at an early stage as a result of a job change leading to her leaving the Region.

At Auckland I am/have been the main supervisor for eleven PhD students, and secondary supervisor for several others. Six of those for whom I have been primary supervisor have been awarded their PhD; and the remainder are relatively recent registrations. From 2002-2004 I was designated supervisor for a postdoctoral student, Abigail Wroe, funded through the Wellcome Foundation.

Summary/comment

Over the years I have developed a considerable amount of teaching experience; moreover the variety of demands has ensured that this has encompassed a *range* of topics, rather than a simple repetition of similar material year after year. I am therefore able to provide a useful teaching contribution in a number of areas.

Administrative experience

Current university responsibilities;

In my present post I undertake a number of administrative roles, including membership of Faculty and of Senate. I have previously been a member of the University's Human Subjects Ethics Committee. From time to time it has also been necessary for me to act as Head of Department in the absence of the incumbent.

Previous university responsibilities

In my previous posts I have held a number of responsibilities, including Directorship of the Clinical Psychology training programme at Liverpool University, Head of the Health Studies Research Division at Bangor and a number of periods as acting Head of Department whilst at Liverpool. I have of course also sat on a number of committees both permanent (e.g. Senate) and ad hoc (e.g. the Senate Information Services Committee at Bangor, the Due Diligence committee for e-learning at Auckland) as part of my normal responsibilities as a senior academic within these organisations.

Responsibilities outside the university

My close links with health care provision have, on a number of occasions, led to my holding positions of administrative responsibility outside the university, particularly within the health service. In the past I have been a member of the Board of Trustees of the South Auckland Hospice and have sat on a number of Health Service and Government committees including the Gwynedd Research and Development Committee, the Gwynedd Postgraduate Medical Board and the Welsh Scheme for Health and Social Research. I was also a member of the committee appointed by the UK Government to oversee implementation of the recommendations of the Blom-Cooper report into misconduct at Ashworth Hospital (Recommendation 45)

From 2000-2002 I was a member of Council of the International Society for Behavioural Medicine, and closely involved in the planning of that organisation's Brisbane and Helsinki conferences.

Whilst in the UK I also held a number of positions within the British Psychological Society, including membership of Council, variously Chair and Secretary of the DCLP training committee, and the Membership and Qualifications Board. I have been a member of accreditation teams for the following courses;

MSc in Applied Criminological Psychology, Birkbeck College 1989
Clinical Psychology Training Scheme, NW Thames, 1986
MSc in Clinical Psychology, NE London Polytechnic, 1983

I have also at various times represented the Universities of which I have been a member on such things as consideration of applicants to the undergraduate medical course and the appointment of consultant medical staff.

From 2006-2008 and 2010-2011 I was President of the Independent Forensic Practitioners Institute.

Summary/comment

Responsibilities such as these reflect the way in which my abilities have been recognised at local and national level and demonstrate the range of administrative tasks with which I have previously had to deal.

External Assessing, Editing and Reviewing

Journals

I have acted as external reviewer to the following journals;

British Journal of Psychology
British Journal of Medical Psychology
British Journal of Developmental Psychology
The Journal of Psychosomatic Research
British Journal of Radiology
Irish Journal of Psychology
Current Psychological Research and Reviews
Journal of Sports Sciences
New Zealand Journal of Sports Medicine
Health Psychology
Social Science and Medicine
British Journal of Clinical Psychology
British Journal of Psychiatry
Psychology and Health
Behavioural Psychotherapy
Human Relations
The Psychologist
Health and Social Care in the Community
New Zealand Journal of Medicine
Psychology, Health and Medicine
Behaviour Modification
Asian Journal of Social Psychology

I am Associate Editor of *Behavioral Sciences of Terrorism and Political Aggression*, have been guest editor (with Prof. C E Lee) of *Health Psychology* and am a member of the editorial board of *Psychology, Health and Medicine* and *British Journal of Health Psychology.*

Grant/Book Proposals

I have reviewed grant proposals for the Welsh Office, the Queen's Nursing Institute, the Irish Health Board, the Health Research Council (NZ) and Chester College. I have acted as book proposal reviewer for the Oxford University Press and the Open University.

External examining

I have acted as external examiner to the following;

Coventry University (Master's Degree in Health Studies)
Queen's University, Belfast (Master's Degree in Clinical Psychology)
University of Surrey (Master's Degree in Clinical Psychology)
Salford University (Postgraduate thesis)
Newcastle University (Postgraduate thesis)
The Institute of Psychiatry (Postgraduate thesis)
The Association for Psychological Therapies (Advanced Course in Behaviour Modification)
Manchester Metropolitan University (Master's Programme)
University of Canterbury (Master's Programme)
University of Canterbury (Postgraduate thesis)
University of Wollongong (Postgraduate thesis)
University of Birmingham (Postgraduate Clinical theses)
University of Lancaster (Postgraduate Clinical theses)
Auckland University of Technology (Postgraduate theses)

External Assessor

I have acted as external assessor for appointments at Queen's University Belfast, the North-West Clinical Psychology Training Course (UK), the Psychological Society of Ireland's Diploma in Clinical Psychology and for Chester College. I was Chair of the Board of Examiners for the PSI's Diploma in Clinical Psychology.

Summary/comment

It will be clear from the above that my expertise is frequently sought in a variety of areas, ranging from the broadly general to the highly specific.

Research Grants

1986	£2,550 for project *Determinants of cancer-related behaviour*, Research Development Fund, Liverpool University
1986	£58,117 for project *Psychological effects of patient choice of treatment in breast cancer* Cancer Research Campaign (With S J Leinster and P D Slade)
1987	£3,220 for project *Perception of risk in an AIDS high-risk Group* Chester City Council
1988	£500 for project *High-risk behaviour of drug users* Chester City Council
1990	£40,992 for project *Preference for choice in breast cancer patients* MacMillan Cancer Relief (With L Degner, K Luker and S J Leinster)
1991	MRC Advanced Studentship in Nursing Research (Student Ms A Caress), value approximately £48,000 (With K Luker)
1991	£97,909 for project *Quality of life and quality of care in epilepsy* Wellcome Trust (with D Chadwick and S Graham-Jones)
1992	£3,000 for project *Problems of carers of dementing elderly relatives* University of Wales (with M Nolan)
1992	£12,000 for project *An evaluation of the framework for continuing education* Welsh National Board (with M Nolan)
1993	£44,745 for project *Preference for information and participation in decision making in women newly diagnosed with breast cancer* MacMillan Cancer Relief (with K Luker and S J Leinster)
1993	£20,000 for project *Family impact of childhood atopic eczema* National Eczema Society (With P Reid, A Finlay and S Lewis-Jones)
1993	£10,599 for project *Support networks and sources of stress among Hospice at Home nurses* Welsh Office (with L Crowther)
1993	£5,000 for project *Juror's perceptions of evidence in child sexual abuse* Research Development Fund, Liverpool University (with J Hutton and D V Glasgow)
1993	£1,000 for project *Auditing the Hospice at Home* Welsh Office
1994	£1,500 for project on the 'Glass Ceiling', the Library Association (with M Curran and F Poland)
1995	$NZ40,000 Lang Scholarship for PhD student Jeanne Reeve for project *Psychological aspects of screening for genetic cancers*
1998	$NZ20,000 extension to third year of Lang Scholarship (J Reeve)
1998	Postdoctoral scholarship (three years) from Wellcome Foundation (UK) re. Dr A Wroe, 1999 - 2002. Total value of grant approximately $NZ200,000
1999	$NZ1,500 from University of Auckland, for cross-cultural study of perceptions of euthanasia (with K Mitchell and J Duckitt)
2010	$NZ875,000 (approximate equivalent from $US) from US Department of Justice for project on reliability measures in bloodstain analysis (with T Laber & Paul Kish [US collaborators] and M C Taylor [NZ collaborator])

Summary/comment

By and large I have generally found it possible to obtain funding for most of the research I have wished to conduct, with grants to the equivalent of nearly two million New Zealand dollars over the course of my career.

Clinical Activities

Throughout my career I have provided a clinical service, almost always (except under circumstances where the case has been referred on from a private clinic) at no charge to recipients or service providers. The types of problems I deal with extend well beyond those related to my research, although the latter problems are inevitably disproportionately represented amongst those I see, especially those relating to eating disorders and to cancer care. The main sources and types of referral have included;

Patients in terminal care, particularly referrals from hospices
Referrals from within the University and local Health Providers
Referrals from other clinical and/or sports psychologists
Referrals from medical colleagues
Other referrals including self-referrals.

I have also acted as clinical supervisor to trainees on placement from 1983-1991, and to graduates working towards Registration (NZ) from 1996-1998.

Until leaving the UK I was sports psychologist to the British Transplant Olympic Team, and supervised a clinical psychologist working towards accreditation as a sports psychologist. In New Zealand I provided sports psychology support to the women's Olympic soccer team for the Beijing games.

Other Professional Activities

I have been involved at various levels with a number of projects not referred to elsewhere, my advice being sought by researchers planning or conducting projects in areas ranging from Dentistry to Accident and Emergency Surgery, and some years ago from the Beijing National Academy of Sciences following the Sichuan earthquake. I have made a number of radio and television appearances, both in the UK and New Zealand, discussing psychological matters. I am current president of the Independent Forensic Practitioners Institute. I provide frequent psychological input in legal cases and have testified in court on numerous occasions.

Additional Information

Additional Skills

I am familiar with a variety of computer languages including Fortran, Pascal, Basic, HTML, Forth and Z80 assembler. Since 1971 I have had experience of a wide range of computers including IBM, ICL, DEC and various small and microcomputers including Macintosh and PC machines. I have experience of a large number of software packages including SPSS (-X, -PC, and Windows), Dbase, WordPerfect, MS Office, Mathematica etc.

I have attended a number of post-qualification courses including Social Skills training, vocational guidance assessment, groupwork etc.

I hold current full UK and New Zealand driving licences, and a current New Zealand Private Pilot's Licence. I have passed all the theoretical examinations for Commercial Pilot's Licence

Other relevant activities

I provide a service in a voluntary capacity to a number of charitable institutions and other 'good causes' especially those concerned with terminal care (hospices etc). These services include lectures, training workshops, team building exercises, conflict resolution strategies etc.

Summary/comment

Over the years I have acquired a wide range of skills and experience, despite the pressures involved in maintaining a heavy teaching load and a regular clinical commitment.

Other interests

Outside of my academic interests I have a long history of participation in various sporting activities at a range of different levels. As a judo player I have competed at international level (I hold the grade of 2nd Dan) including two World Student Judo Championships. In 1990, at the age of 40, I was selected as a member of a team to tour Japan for a series of matches, and the same year was North Wales Under 60Kg Champion. I retired from judo in 1997 having taken second place in the Men's Under 60Kg category of the New Zealand National Judo Championships and second place in the Under 70Kg category of the North Shore Masters' (over 35 years) Championships.

As a track and field athlete I have competed at club level at a range of events, my achievements including winning the 1989, 1990 and 1992 Clwyd Pole Vault Championships, the 1991 Clwyd Decathlon Championships, and the 1991 Northern Counties (UK) 110m hurdles and triple jump championships (veteran's class). Within Modern Pentathlon and its subsets I have competed at a number of levels and at the time of leaving the UK was the Welsh Modern Triathlon Champion. I have run approximately 30 marathons and completed 6 decathlons. As a member of New Balance Owairaka Athletic Club I have been a member of the club team in the National Road Relays and the Division 1 Track and Field League. In 1997 I won the Over 45 category in the North Harbour Masters' Swimming Championships and as mentioned above I took second place in the New Zealand National Judo Championships. I have completed the Rangitoto to St Heliers swims seven times since 1998. I also participate in occasional aviation competitions.

At a recreational level I participate in SCUBA diving, waterskiing, aviation, windsurfing, rock climbing and aerial circus activities.

At a less physically demanding level, I enjoy recreational mathematics, crossword puzzles, and reading.

Summary/comment

I hope that the information given above will help to show that I am not simply an obsessive academic, single-mindedly pursuing my subject to the exclusion of all else. Although I have had the occasional success in my recreational activities, they are motivated by the enjoyment of the pastime rather than by any external indicator of achievement. I believe that my involvement in these activities brings a range of personal benefits in terms of my own ability to address the challenges presented in work and play.

Part 2: Presentations and Publications

Selected conference presentations

1. **Owens, R G**, and Ashcroft, J B *"Decision making in clinical psychology; a formalisation"* Presented to Joint Scottish/Irish conference on 'Behaviour Modification and its Supporting Disciplines', Islay, Argyllshire, 1974
2. **Owens, R G**, Oxford, D J, and MacKrell, K *"On Chomsky's views of Skinner's 'Beyond Freedom and Dignity'"* Presented to Experimental Analysis of Behaviour Group Annual Conference, Bangor, 1974
3. **Owens, R G** *"Fixed-Interval button pressing by humans"* Presented to Experimental Analysis of Behaviour Group Annual Conference, London 1975
4. **Owens, R G** *"Measurement of the strength of conditioned reinforcers in human operant behaviour"* Presented to Experimental Analysis of Behaviour Group Annual Conference, Exeter, 1977
5. **Owens, R G** *"Addiction, reinforcement and reduction of behaviour"* Presented to the Fourth Annual Conference on Alcoholism and Drug Dependence, Liverpool 1978
6. **Owens, R G** *"On people and pigeons"* Presented to the Conference of the Scottish Association for Behaviour Modification, Islay, Argyllshire 1978
7. **Owens, R G** *"Astrology and Psychology"* Presented to the Annual Psychological Assistants' Conference, Wakefield 1978
8. **Owens, R G** *"What's radical about radical behaviourism"* Presented to the Psychology Society, Brunel University, 1978
9. **Owens, R G** *"What statistics should psychology use – if any?"* Presented at the Easter Conference of the Royal Statistical Society, Oxford, 1979
10. **Owens, R G** *"Some reflections on indirect measurement"* Presented to DHSS symposium on 'Assessment and Treatment of Sexual Deviation; Issues and Trends', Liverpool 1979
11. **Owens, R G**, and Ashcroft, J B *"The psychology of violence"* Presented to Mersey Regional Health Authority Conference on 'Procedures for dealing with violence on Health Service premises', Liverpool 1980
12. **Owens, R G**, *"Radical Psychology and radical politics"* Presented to the North East Branch of the Division of Clinical Psychology conference on 'Some alternatives for clinical practice', Leeds 1980
13. **Owens, R G** *"Functional analysis in clinical psychology"* Presented at the Psychology Department, North East London Polytechnic, 1981
14. **Owens, R G**, and Ashcroft, J B *"Functional analysis in clinical psychology"* Presented to Norfolk branch of the Division of Clinical Psychology, Kings Lynn, 1982
15. **Owens, R G**, and Bagshaw, M *"First steps in the functional analysis of aggression"* Annual Merseyside Course in Clinical Psychology, Liverpool 1982
16. **Owens, R G** *"The relationship between sexual arousal and sexual behaviour"* Presented to the Annual Special Hospitals Conference, Rampton Hospital, 1982
17. **Owens, R G** *"The functional analysis of aggressive behaviour"* Presented at Leytonstone Hospital, London 1982
18. **Owens, R G** *"The functional analysis of clinical problems"* Presented to the North East Thames Division of Clinical Psychology conference on 'Integrating psychological approaches', North East London Polytechnic, London 1983
19. **Owens, R G** *"Radical behaviourism and clinical psychology"* Presented to the Psychology Department, University of Leicester, 1983
20. **Owens, R G** *"Concepts in Applied Behaviour Analysis"* Presented to the Psychology Department, University of Leicester, 1984
21. **Owens, R G** *"New developments in psychology and the law"* Presented to Special Annual Merseyside Course in Clinical Psychology, Chester 1984
22. **Owens, R G** *"Radical behaviourism and psychotherapy; the common ground"* Presented to Northern Branch of the Psychology and Psychotherapy Association, Liverpool 1984
23. Hardley, E M, and **Owens, R G** *"Scientific fraud and its implications for psychology"* Presented to the London Conference of the British Psychological Society, 1984

24. Ashcroft, J J, and **Owens, R G** "*Informal Decision Analysis and choice of treatment by breast cancer patients*" Presented to Annual Conference of the British Psychological Society, Swansea, 1985
25. **Owens, R G** "*Attitudes to child sexual abuse*" Presented at the Wilhelmina Kinderziekenhuis, Utrecht, Netherlands 1985
26. **Owens, R G** "*Psychological aspects of breast cancer*" Presented at the Academisch Ziekenhuis, University of Utrecht, 1985
27. **Owens, R G** "*Computer applications in clinical psychology*" Presented at the Psychology Department, University of Leiden, 1985
28. **Owens, R G** "*Psychology and cancer*" Presented at the Academisch Ziekenhuis, University of Limburg, 1985
29. **Owens, R G** "*Psychology and general medicine*" Presented at the Academisch Ziekenhuis, Leiden, Netherlands 1985
30. **Owens, R G** "*Psychological aspects of food intolerance*" Presented at the Royal Society of Medicine, London 1985
31. **Owens, R G**, Ashcroft, J J, Leinster, S J, and Slade, P D "*Psychological effects of the offer of breast reconstruction following mastectomy*" Presented at the annual conference of the British Psychosocial Oncology Group, London 1985
32. **Owens, R G** "*Breast self-examinatino and presentation of symptoms; some findings and problems*" Presented at the annual conference of the British Psychosocial Oncology Group, London 1985
33. **Owens, R G** "*Scientific fraud*" Presented at Lancashire Polytechnic, Preston, 1986
34. **Owens, R G**, and Hardley, E M "*Scientific fraud; implications for psychology and psychiatry*" Presented at the University of Edinburgh, 1986
35. **Owens, R G** "*Facing death*" Presented at the University of Manchester, 1987
36. **Owens, R G** and Naylor, F "*Dying; the patient's perspective*" Presented at symposium on Death and Bereavement, Southport, 1987
37. **Owens, R G**, Deadman, J M, and Leinster, S "*Psychological aspects of breast cancer*" Presented at Second Conference of European Health Psychology Society, Trier, Germany 1988
38. **Owens, R G** and Blackmore, S "*Near-Death Experiences*" Presented to Annual Merseyside Course in Clinical Psychology, Chester 1989
39. **Owens, R G** "*The experience of dying*" Presented to Association for Psychological Therapies Conference on 'Dying and Bereavement', UMIST, Manchester 1990
40. **Owens, R G** "*Caring for dying people*" Presented to North-West Conference of British Dietetic Association, Clatterbridge Hospital, Wirral 1990
41. **Owens, R G**, Deadman, J M, and Leinster, S J "*Patient choice of treatment in breast cancer*" Presented at the Newcastle Polytechnic, 1990
42. **Owens, R G** "*Dying and sexuality*" Presented to the MacMillan Nurses' Conference, Ormskirk, Lancs 1990
43. **Owens, R G** "*Dying*" Presented to Leicestershire Terminal Care Group, Leicester 1990
44. **Owens, R G** "*Researching the unresearchable*" Guest lecture at the Clinical Research Nurses' Association Conference, Liverpool 1991
45. **Owens, R G**, Smith, H C, and Leinster, S J "*An experimental study of informal decision analysis as an aid to choice of treatment in breast cancer*" Presented at Third Conference of European Health Psychology Society 1991
46. Hutton, J L, **Owens, R G**, Baker, G, Smith, H C, and Ashcroft, J J "*Turning patients into Bayesians*" Presented at the Fourth Valencia Meeting on Bayesian Statistics, 1991
47. **Owens, R G**, Prasad, R, and Leinster, S J "*Takeup of breast screening by different ethnic groups*" Presented to Fifth European Health Psychology Society Conference, Lausanne, Switzerland 1991
48. Baker, G, and **Owens, R G** "*Quality of Life in epilepsy*" Presented to Fifth European Health Psychology Society Conference, Lausanne, Switzerland, 1991
49. Hutton, J, and **Owens, R G** "*Evaluating prior beliefs about sexual abuse*" Presented to the International Conference on Applied Bayesian Statistics, Nottingham 1992
50. Baker, G, and **Owens, R G** "*Refinement of a health-related disease-specific Quality of Life measure for patients with intractable epilepsy*" Presented to Sixth European Health Psychology Society Conference, Leipzig, Germany 1992
51. Flynn, A, **Owens, R G**, Morton, J, and Dewey, M E "*Disclosure of information to seriously ill and dying patients; what do young people think?*" Presented to Sixth European Health Psychology Society Conference, Leipzig, Germany 1992

52. **Owens, R G** "*Multiattribute Utility Theory and Quality of Life*" Presented to Statistics and Medicine Group, Liverpool, 1991
53. **Owens, R G** "*Psychological aspects of cancer*" Presented to the Gwynedd Research Interest Group, Llandudno, 1992
54. **Owens, R G** "*Medical applications of Multiattribute Utility Theory*" Presented to Gwynedd Postgraduate Medical Group, 1992
55. **Owens, R G** "*Radical behaviourism, ethics, and life-death decisions*" Presented at London Conference of British Psychological Society, 1992
56. **Owens, R G** and Baker, G A "*Psychological contributions to terminal care*" Presented to the Joint Health Psychology/Psychobiology conference, St Andrews, 1992
57. Harrison, J, Glass, C A, and **Owens, R G** "*Psychosexual functioning in women with spinal cord dysfunction*" Presented at Seventh European Health Psychology Society Conference, Brussels 1993
58. Beaver, K, Leinster, S J, Luker, K, and **Owens, R G** "*Preferences for decision making in women newly diagnosed with breast cancer*" Presented at the 78th meeting of the Surgical Research Society, Dundee, Scotland 1993
59. **Owens, R G** "*Applications of decision analysis in health care*" Presented at the University of Leiden, Department of Clinical and Health Psychology, 1993
60. **Owens, R G** and Rodriguez-Marin, J Invited discussants, "*Psychosocial oncology*", Seventh European Health Psychology Conference, Brussels 1993
61. **Owens, R G** "*The psychology of chronic pain*" Opening address at inaugural meeting of the Welsh Pain Society, 1994
62. **Owens, R G** and Glass, C A "*Treatment of spinal cord injury*" Presented at NZ conference on Aviation Psychology, Auckland 1995
63. **Owens, R G** "*Psychological contributions to terminal care*" Keynote address, New Zealand Psychological Society Conference, Christchurch, 1996
64. **Owens, R G** "*Dreams and nightmares of dying people*" Keynote address, Turkish Psychological Society Conference, Istanbul, 1996
65. **Owens, R G** Invited discussant, symposium on "*Psychological aspects of palliative care*", Tenth European Health Psychology Conference, Dublin, 1996
66. **Owens, R G** "*Back to basics*" Keynote address, New Zealand Health Psychology Conference, Okoroire, 1998
67. Kent, B, and **Owens, R G** "*Attitudes to corneal and organ donation*" Presented at Eighth European Health Psychology Society Conference, Alicante, Spain, 1994
68. **Owens, R G**, Austen, S, and Briggs, J "*Terminal care of people with learning disabilities*" Presented at Tenth European Health Psychology Society Conference, Dublin, 1996
69. Lawrence, G E, **Owens, R G**, Ozaydin, G, Ozakinci, G, and Yilliz, B "*Information needs of cancer and cardiac patients*" Presented at Tenth European Health Psychology Society Conference, Dublin, 1996
70. Lub, X, Bijn, T v.d., and **Owens, R G** "*Nightmares of dying patients*" Presented at Tenth European Health Psychology Society Conference, Dublin, 1996
71. Bar-Hava, G, and **Owens, R G** "*Can psychological interventions increase life expectancy in cancer patients?*" Presented at Annual New Zealand Health Psychology Conference, Okoroire, 1997
72. Haase, A, Prapavessis, H, and **Owens, R G** "*Perfectionism and eating attitudes among rowers: Moderating effects of body mass, weight classification and gender*" Presented at Australian Conference of Science and Medicine in Sport, Canberra, 1997
73. Reeve, J, and **Owens, R G** "*The New Zealand experience of genetic testing for hereditary cancer: a qualitative approach*" Presented at 11th Conference of the European Health Psychology Society, France, 1997
74. **Owens, R G** "*Steroid use in sport is not unethical, just undesirable*" Presented at Australian Conference of Science and Medicine in Sport, Adelaide, 1998
75. **Owens, R G** "*Functional analysis; a bridge between the qualitative and the quantitative?*" Presented at Annual New Zealand Health Psychology Conference, Okoroire, 1999
76. Taufa, P, and **Owens, R G** "*Investigating Tongan perceptions of hospice provision*" Presented at Annual New Zealand Health Psychology Conference, Okoroire, 1999
77. **Owens, R G**, Lub, X, and Thompson, J "*Are Nightmares in dying Patients a Reflection of Anxiety?*" Presented at European Association for behavioural and Cognitive Therapies, Dresden, 1999

78. **Owens, R G** *"Reinforcement theory and the study of Perfectionism; lessons for problems in Sports Psychology"* Presented at 5th IOC World Congress, Sydney, 1999
79. Haase, A M, **Owens R G**, and Prapavessis, H *"Positive and negative perfectionism: Domain-specific or global construct?"* Presented at 6th International Congress of Behavioural Medicine, Brisbane, 2000
80. **Owens, R G**, Slade, P D, Haase, A, Cox, K, and Prapavessis, H *"Being too perfect: Perfectionism and health"* Presented at 6th International Congress of Behavioural Medicine, Brisbane, 2000
81. Wroe, A L, and **Owens, R G** *"Adherence to medical treatments: An investigation of decision making"* Presented at 6th International Congress of Behavioural Medicine, Brisbane, 2000
82. Mitchell, K, and **Owens, R G** *"Decision-making Process in End of Life Treatment Choices"* Presented at New Zealand Health Psychology Conference, Auckland, 2001
83. **Owens, R G** *"Psychology and ethics in end-of-life decision making"* Presented at New Zealand Health Psychology Conference, Auckland, 2001
84. Reeve, J, **Owens, R G**, and Winship, I *"Genetic Testing – A Mind Altering Practice"* Presented at New Zealand Health Psychology Conference, Auckland, 2001
85. Wroe, A L, and **Owens, R G** *"Adherence to Medical Treatments: Investigations of Decision Making"* Presented at New Zealand Health Psychology Conference, Auckland, 2001
86. Wroe A L, and **Owens, R G** *"Intentional and Unintentional Nonadherence: A study of decision making"* Presented at European Health Psychology Society Conference, Scotland, 2001
87. Mitchell, K, and **Owens, R G** *"Till Death Do Us Part"* Presented at European Health Psychology Society Conference, Scotland, 2001
88. Reeve, J, **Owens, R G**, and Winship, I *"Genetic Testing for Familial Cancers: A life altering event of just another piece of the puzzle?"* Presented at European Health Psychology Society Conference, Scotland, 2001
89. **Owens, R G** *"Patient decision-making in breast cancer; recent qualitative data"* Presented at NZ Health Psychology/Behavioural Medicine conference, Auckland 2002
90. Mitchell, K, and **Owens, R G** *"Hastening death – judgements on justifiability by the elderly"* Presented at NZ Health Psychology/Behavioural Medicine conference, Auckland 2002
91. **Owens, R G** "Where is the 'B' in CBT?" Presented at European Conference of Cognitive Behaviour Therapy, Manchester 2004 (Invited presentation)
92. **Owens, R G** "Perfectionism; a pluralistic approach?" Presented at international meeting on the study of Perfectionism, Kent, UK, 2008
93. **Owens, R G** "The end of moral philosophy?" Presented to annual conference of NZ Sceptics, Hamilton 2008 (invited presentation)
94. **Owens, R G** and Dobson, R "The impact of childhood cancer on siblings" Presented at the British Psychological Society's Health Psychology Conference, Aston 2009
95. **Owens, R G** "Quality-of-life and end-of-life care" Presented at International Conference on Quality of Life, Auckland University of Technology 2010 (invited presentation)
96. Zuo, Li and **Owens, R G** "Insomnia; Ilness perceptions and interest in drug-free treatment" Presented at the 4th Asian Health Psychology Conference, Taiwan, 2010
97. **Owens, R G,** "Self-regulation and decisions regarding infant immunisation" Presented at the 4th Asian Health Psychology Conference, Taiwan, 2010
98. **Owens, R G,** Taylor, M and Yuen, S "Reliability and confidence in blood pattern analysis" Presented at the BPS Division of Forensic Psychology Conference, Portsmouth, 2011
99. **Owens, R G** "Dementia, Depression and Health Care Planning" Invited presentation, Henry G Leong Foundation symposium on dementia care, Hong Kong University, 2012.
100. Gaab, E, **Owens, R G,** & McLeod, R "The Voices of Young People Involved in Paediatric Palliative Care" Presented at European Health Psychology Society conference, Budapest, 2012
101. Bavin, L & **Owens, R G** "Education-Entertainment; effects of a fictional TV programme on drinking attitudes and intentions" Presented at the Division of Health Psychology Annual Conference, Liverpool 2012
102. **Owens, R G** "Why moral philosophy will never solve the euthanasia problem" Presented at the Death, Dying and Disposal conference, Open University, Milton Keynes 2013

103. **Owens, R G** "Blame Darwin; why evolution is to blame for many of our health problems". Presented at the International Conference on Education, Psychology and Sociology, Tapei 2014
104. **Owens, R G** "Assisted dying in Australasia" Presented at International Conference on End of Life, Brisbane, 2014 (Invited presentation)

PUBLICATIONS

Books:

1. **Owens, R G** and Ashcroft, J B "*Violence; a guide for the caring professions*" Croom Helm, Beckenham, 1985
2. Ashcroft, J J, and **Owens, R G** "*Weight control in pregnancy*" Thorsons, Wellingborough, 1986
3. Ashcroft, J J, and **Owens, R G** "*Watch your child's weight*" Oxford University Press, 1987
4. **Owens, R G**, and Naylor, F "*Living while dying*" Thorsons, Wellingborough, 1989
5. Cormack, M A, **Owens, R G**, and Dewey, M E "*Reducing benzodiazepine consumption; a psychological contribution to general practice*" Springer-Verlag, New York, 1989
6. Brodie, D A, Williams, J, and **Owens, R G** "*Research methods in physical education and movement science*" Harwood, Switzerland 1994
7. Poland, F M, Curran, M, and **Owens, R G** "*Women and senior management*" The Library Association, London 1996
8. Lee, C E and **Owens, R G** "The Psychology of Men's Health" Open University Press, Milton Keynes 2002

I was also been responsible (jointly with Professor Christina Lee) for editing a special issue (2002) of the Journal of Health Psychology, on the subject of men's health.

Contributions to books:

1. **Owens, R G** "*Addiction, reinforcement and reduction of behaviour*" in "Aspects of Alcohol and Drug Dependence" by J S Madden, R Walker and W H Kenyon (eds), Pitman Medical 1981 pp 185-192
2. **Owens, R G** "*Forensic issues in psychology*" in "Current Issues in Clinical Psychology vol. 1" by E Karas (ed), Plenum, NY, 1983 pp 17-22
3. Ashcroft, J B, and **Owens, R G** "*Computer applications in clinical psychology*" in "Current Issues in Clinical Psychology vol. 1" by E Karas (ed), Plenum, NY, 1983 pp 107-110
4. **Owens, R G** "*Psychological Assessment*" in "The Scientific Principles of Psychopathology" by P McGuffin, M F Shanks and R J Hodgson (eds), Academic Press, London 1984 pp 505-522
5. **Owens, R G**, and Bagshaw, M "*First steps in the functional analysis of aggression*" in "Current Issues in Clinical Psychology vol. 2" by E Karas (ed), Plenum, NY, 1985 pp 285-307
6. **Owens, R G** "*The relationship between sexual arousal and sexual behaviour*" in "Sexual Assessment: Issues and Radical Alternatives" by P S Pratt (ed), British Psychological Society, Leicester 1986 pp 18-23
7. **Owens, R G**"*New developments in psychology and the law*" in "Current Issues in Clinical Psychology vol. 4" by G Edwards (ed), Plenum, NY, 1986, pp 107-110
8. **Owens, R G**, Ashcroft, J J, and Duffy, J E "*Early detection and presentation of breast cancer*" in "Current Issues in Clinical Psychology vol 5" by N Eisenberg and D V Glasgow (eds), Gower, Aldershot 1986 pp 263-269
9. **Owens, R G** "*Handling strong emotions*" in "A Handbook of Communication Skills" by O Hargie (ed), Croom Helm, Beckenham and New York University Press 1986, pp 383-405
10. **Owens, R G** "*Radical behaviourism and the ethics of clinical psychology*" in "Psychology, Ethics and Change" by S Fairburn and G Fairburn (eds), Routledge, 1987 pp 91-114
11. **Owens, R G**, Ashcroft, J J, Leinster, S J and Slade, P D "*Psychological effects of the offer of breast reconstruction after mastectomy*" in "Psychosocial Oncology" by M Watson and S Greer (eds), Pergamon, Oxford 1988 pp 113-118
12. **Owens, R G** "*Breast self-examination and presentation of symptoms; some findings and problems*" In "Psychosocial Oncology" by M Watson and S Greer (eds), Pergamon, Oxford 1988 pp 71-76
13. **Owens, R G** and Scott-Fordham, A "*Psychology and the law*" in "Careers in Psychology", British Psychological Society, Leicester, 1988 pp 34-37
14. **Owens, R G**, Slade, P D, and Fielding, D M "*Patient series and quasi-experimental designs*" in "A Handbook of Skills and Methods in Mental Health Research" by G Parry

and F Watts (eds), Lawrence Erlbaum, Hove 1989 pp 189-209 Revised version in second edition 1996, pp 229-251

15. **Owens, R G** and MacKinnon, S A "*Functional analysis and challenging behaviour; some theoretical and conceptual problems*" in "Functional Analysis and Challenging Behaviour" by R S P Jones and C Eayrs (eds), British Institute of Mental Handicap, 1993
16. **Owens, R G** "*Legal and psychological concepts of mental status*" in "A Handbook of Psychology in Legal Contexts" by D Carson and R Bull (eds), John Wiley and Sons, 1995
17. **Owens, R G** "*Behaviourist approaches to adult learning*" in "Adult Learning" by Peter Sutherland (ed), Kogan Paul
18. **Owens, R G** "*Self-examination; breasts, testicles*" in "The Cambridge Handbook of Psychology, Health and Medicine" by R West, A Baum, C McManus, S Newman and J Weinman (eds), Cambridge 1997
19. **Owens, R G** and Payne, S A "*Qualitative Research in the Field of Death and Dying*" in "Qualitative Research in Health Psychology" by M Murray and K Chamberlain (eds) Sage, London, 1999
20. **Owens, R G** "*Ethics, aesthetics, and empiricism*" in "Business Ethics in Theory and Practice" by P A Werhane and A Singer (eds), Kluwer 1999
21. **Owens, R G** "Generalizability theory" in "Reader's Guide to The Social Sciences" Vol. 2, by Michie (ed), Fitzroy Dearborn, London 2000
22. **Owens, R G** "Human Longevity" in "Reader's Guide to The Social Sciences" Vol. 2, by J Michie (ed), Fitzroy Dearborn, London 2000
23. **Owens, R G** "Single-case research" in "Reader's Guide to The Social Sciences" Vol. 2, J Michie (ed), Fitzroy Dearborn, London 2000
24. **Owens, R G** "The nature of evidence in health psychology" in "Handbook of Clinical Health Psychology" by Susan Llewellyn and Paul Kennedy, John Wiley & Son 2003
25. **Owens, R G** "Men's Health" in "International Encyclopaedia of Social and Behavioral Sciences" by James D Wright(ed).

Abstracts, letters, brief communications etc

1. **Owens, R G**, Oxford, D J, and MacKrell, K "*On Chomsky's views of Skinner's 'Beyond Freedom and Dignity'* Behaviour Modification Newsletter 7, 1975, 11-17
2. **Owens, R G** "*Reply to 'A note on About Behaviorism'* Behaviour Modification Newsletter **10**, 1976, 30-31
3. **Owens, R G** "*What statistics should psychology use – if any?*" Royal Statistical Society Oxford Conference Abstracts 1979 (abstract)
4. **Owens, R G** "*Analytical, methodological, metaphysical and now naïve behaviourism*" Behaviour Modification Newsletter, Home Office 1979 pp 4-7
5. **Owens, R G** "*Psychology and astrology*" New Humanist **195**, 1980, 142-143
6. **Owens, R G** "*Radical behaviourism; changing the world*" Changes 1982, 89
7. **Owens, R G** "*Simpson's rule and the area under the normal curve*" Practical Computing **5**, 1982, 147
8. Hardley, E M, and **Owens, R G** "*Fraud in science and its implications for psychology*" Bulletin of the British Psychological Society **38**, 1985, A35 (abstract)
9. **Owens, R G** "*Statistics in psychology; the decline and fall*" Bulletin of the British Psychological Society **38**, 1985, A35 (abstract)
10. **Owens, R G** "*Psychotherapy research; a fable*" Clinical Psychology Forum **10**, 1987, 28-30
11. Pearce, C E, and **Owens, R G** "*Research report; investigating patients' perceptions and expectations of pain*" Nursing Times **84**, 1988, 64
12. **Owens, R G** and Deadman, J M "*Use of the case in scientific research*" British Psychosocial Oncology Group Newsletter Jan 1989, 9-13
13. **Owens, R G** "*Research report; Near Death Experiences*" Health Psychology Update 1990
14. Leinster, S J, Deadman, J M, **Owens, R G**, and Slade, P D "*The effect of patient choice of treatment on psychological outcome of patients with breast cancer*" Proceedings of International Conference on Breast Cancer, Cancer Treatment Reports (Supplement), 1990
15. **Owens, R G** "*Testing times*" Nature **349 (3609)**, 1991, 469 (letter)

16. Baker, G A, and **Owens, R G** *"Refinement of a health-related disease specific quality of life measure for patients with intractable epilepsy"* in "Health Psychology in a Changing Europe" by H Schroder and K Reschke (eds), Quintessenz Verlags GMbH, Munich 1992 (abstract)
17. Flynn, A, **Owens, R G**, and Dewey, M E *"Disclosure of information to seriously ill and dying patients; what do young people think?"* In "Health Psychology in a Changing Europe" by H Schroder and K Reschke (eds), Quintessenz Verlags GMbH, Munich 1992 (abstract)
18. **Owens, R G** Review of "The Psychology of Health; an introduction" by M Pitts and K Phillips, Routledge, London, 1991. *British Journal of Clinical Psychology* **31**, 1992, 382
19. **Owens, R G** and Baker, G A *"Psychological contributions to terminal care"* The Psychologist **6** (supplement), 1993, 36 (abstract)
20. **Owens, R G** *"Man and beast"* Nature 365 1993, 289 (letter)
21. **Owens, R G** Review of "Exercise Psychology: the Influence of Physical Exercise on Psychological Processes" by P Seraganian (ed), Wiley, New York 1991. *British Journal of Clinical Psychology* **33**, 1994, 125-126
22. **Owens, R G** "Risk factor epidemiology" *Lancet* **343**, 420
23. **Owens, R G** "Review of "I wish I could have told you so" by C Kalus, British Journal of Clinical Psychology **33**, 1994, 421
24. Crowther, L M, **Owens, R G**, and Curran, M "A multivariate approach for investigating support networks and sources of stress among community-based hospice nurses" *Psycho-Oncology* **4**, 85-86 (abstract)
25. **Owens, R G** Review of "A Good Death; Conversations with East Londoners" by M. Young and L Cullen, Routledge, London. *Journal of Health Psychology* 1997, 568-569
26. Reeve, J, Owens, R G, and Winship, I *"The role of psychology in predictive testing"* Journal of Gastroenterology and Hepatology **14 (suppl)**, A80 (abstract)

Journal articles

1 Aylesbury, L J and **Owens, R G** *"Low cost equipment for schedule generation I; fixed and random ratio schedules"* Behaviour Research, Methods and Instrumentation **9**, 1977, 247-252

2 **Owens, R G** *"What do we think we are doing?"* European Journal of Behaviour Analysis and Modification **4**, 1977, 214-220

3 **Owens, R G**, and Aylesbury, L J *"Low cost equipment for schedule generation II; time-dependent schedules"* Behaviour Research, Methods and Instrumentation **10**, 1978, 29-32

4 **Owens, R G** *"Operant conditioning and behaviour modification"* Behaviour Analysis **1**, 1978, 34

5 Aylesbury, L J, and **Owens, R G** *"Low cost equipment for schedule generation III; variable ratio and ancillary circuits"* Behaviour Research, Methods and Instrumentation **11**, 1979, 342-348

6 **Owens, R G** *"Do psychologists need statistics?"* Bulletin of the British Psychological Society 32, 1979, 103-106

7 **Owens, R G** *"Naïve behaviourism and behaviour modification"* Bulletin of the British Psychological Society **33**, 1980, 312-315

8 **Owens, R G** *"Functional analysis in applied psychology"* British Journal of Clinical Psychology **21**, 1982, 181-189

9 Duffy, J E, and **Owens, R G** *"Factors affecting promptness of reporting in breast cancer patients"* Hygie; International Journal of Health Education **2**, 1984, 29-32

10 Edwards, G E, and **Owens, R G** *"The clinical ecology debate; some issues arising"* Bulletin of the British Psychological Society **37**, 1984, 325-328

11 **Owens, R G** and Duffy, J E *"Women's responses to detection of breast lumps; a British study"* Health Education Journal **44**, 1985, 69-70

12 Foster, M A, **Owens, R G**, and Newton, A V *"Functional analysis of the gag reflex"* British Dental Journal **158**, 1985, 369-370

13 **Owens, R G** and Ashcroft, J J *"Breast cancer screening; the way ahead"* Journal of Psychosocial Oncology **4**, 1986, 15-25

14 **Owens, R G**, and Hardley, E M *"Plagiarism in psychology; what can and should be done?"* Bulletin of the British Psychological Society **38**, 1986, 331-333

15 **Owens, R G** and Slade, P D "*Running and anorexia nervosa; an empirical study*" International Journal of Eating Disorders **6**, 771-775

16 **Owens, R G**, Ashcroft, J J, Leinster, S J and Slade, P D "*Informal Decision Analysis with breast cancer patients; an aid to psychological preparation for surgery*" Journal of Psychosocial Oncology **5**, 1987, 23-34

17 **Owens, R G**, Daly, J, Heron, K, and Leinster, S J "*Psychological and social characteristics of attenders for breast screening*" Psychology and Health **1**, 1987, 303-313

18 Eisenberg, N E, **Owens, R G**, and Dewey, M E "*Attitudes of professional groups to child sexual abuse*" Child Abuse and Neglect; the International Journal **11**, 1987, 109-116

19 Murphy, P, Bentall, R P, and **Owens, R G** "*Opiate abstinence experiences in people who smoke or inject heroin*" British Journal of Addiction 1989, 673-679

20 **Owens, R G** and Heron, K "*Accuracy of estimates of delay by women seeking breast cancer treatment*" Journal of Psychosocial Oncology 1989 **7**, 193-197

21 Deadman, J M, Dewey, M E, **Owens, R G**, and Leinster, S J "*Threat and loss in breast cancer*" Psychological Medicine 1990 **19**, 677-681

22 Cormack, M A, **Owens, R G**, and Dewey, M E "*The effect of minimal interventions by general practitioners on long-term benzodiazepine use*" Journal of the Royal College of General Practitioners **39**, 1990, 408-411

23 Thorp, D, **Owens, R G**, Whitehouse, G W, and Dewey, M E "*Subjective experiences of Magnetic Resonance Imaging*" Clinical Radiology **41**, 1990, 276-278

24 **Owens, R G** and Ghadiali, E J "*Judo as a possible cause of anoxic brain damage*" Journal of Sports Medicine and Physical Fitness **31**, 1991, 627-628

25 Johnson, P, **Owens, R G**, and Dewey, M "*Professionals' attribution of censure in father-daughter incest*" Child Abuse and Neglect; the International Journal **14**, 1990, 419-428

26 Harmon, G A, **Owens, R G**, and Dewey, M E "*Factors affecting rapists' and non-rapists' perceptions of the likelihood of sexual activity*" International Journal of Criminology **35**, 1991, 217-224

27 Jones, R S P and **Owens, R G** "*Applying functional analysis*" Behavioural Psychotherapy **20**, 1992, 37-40

28 **Owens, R G** and Jones, R S P "*Extending the role of functional analysis in challenging behaviour*" Behavioural Psychotherapy **20**, 1992, 45-46

29 Hutton, J, Owens, R G, Horne, L, and Glasgow, D "*Evaluating prior beliefs about child sexual abuse*" Health and Social Care in the Community **1**, 1993, 219-226

30 Hutton, J, and Owens, R G "*Bayesian sample size calculations and prior beliefs about sexual abuse*" The Statistician **42**, 1993, 399-404

31 Harmon, G, **Owens, R G**, and Dewey, M E "*Rapists' and non-rapists' attitudes to women*" International Journal of Offender Therapy and Comparative Criminology **39**, 1995, 269-275

32 Harrison, J, Glass, C A, **Owens, R G** and Soni, B M "*Factors associated with sexual functioning in women following spinal cord injury*" Paraplegia **33**, 687-692 1995

33 Nolan, M, **Owens, R G**, and Nolan, J "*Continuing professional education; identifying the characteristics of an effective system*" Journal of Advanced Nursing **21**, 1995, 551-560

34 Mackenzie, R, Sims, C, **Owens, R G**, and Dixon, A K "*Patients' perceptions of magnetic resonance imaging*" Clinical Radiology **50**, 1995, 137-143

35 Kent, B, and **Owens, R G** "*Conflicting attitudes to corneal and organ donation; a study of nurses' attitudes to organ donation*" International Journal of Nursing Studies **22**, 1995, 484-492

36 Luker, K A, Beaver, K, Leinster, S J, **Owens, R G**, Degner, L, and Sloan, J "*The information needs of women newly diagnosed with breast cancer*" Journal of Advanced Nursing **22**, 1995, 134-141

37 Terry-Short, L, **Owens, R G**, Slade, P D, and Dewey, M E "*Positive and negative perfectionism*" Personality and Individual Differences **18**, 1995, 663-668

38 **Owens, R G** "*Radical behaviourism and life-death decisions*" Clinical Psychology Forum **80**, June 1995, 12-16

39 Luker, K A, Beaver, K, Leinster, S J, and **Owens, R G** "*Meaning of illness for women with breast cancer*" Journal of Advanced Nursing **23**, 1996, 1194-1201

40 Luker, K A, Beaver, K, Leinster, S J and **Owens, R G** "*Information needs and sources of information for women with breast cancer: a follow-up study*" Journal of Advanced Nursing **23**, 1996, 487-495

41 **Owens, R G** *"Going gently into the good night"* New Ethicals **34**, 9-17 1997 Subsequently reprinted in New Zealand Science Monthly

42 Lawson, V I, Lewis-Jones, M S, Finlay, A Y, Reid, P, and **Owens, R G** *"The family impact of chidhood atopic dermatitis; the Dermatitis Family Impact Questionnaire"* British Journal of Dermatology **138**, 1998, 107-113

43 Slade, P D, and **Owens, R G** *"A dual process model of Perfectionism based on reinforcement theory"* Behaviour Modification **22**, 1998, 372-390

44 Hohepa, M, Prapavessis, H, and **Owens, R G** "Behaviour modification therapy for obesity" New Ethicals **36**, 1999, 48-49

45 Haase, A H, Prapavessis, H, and **Owens, R G** "Perfectionism and eating attitudes in competitive rowers; moderating effects of body mass, weight classification and gender" *Psychology and Health* **14** 1999, 643-657

46 Reeve, J, **Owens,** R G and Winship, I M "Psychological impact of predictive testing for colonic cancer" *Journal of Health Psychology* **5**, 2000, 99-108

47 Mitchell, K, and **Owens, R G** "Euthanasia and Palliative Psychology in End-of-Life Care" *Australian Psychologist* **35** (3), November, 2000, 193-200

48 Caress, A, Luker, KA, **Owens, R G** "A descriptive study of meaning of illness in chronic renal disease" *Journal of Advanced Nursing*, **33** (6), 2001, 716-727

49 Deadman, J, Leinster, S J, Owens, R G, Dewey, M E and Slade, P D *"Taking responsibility for cancer treatment"* *Social Science and Medicine* **53**, 2001, 669-677

50 Lee, C E and **Owens, R G** "Men, work and Gender" *Australian Psychologist* **37**, 13-19

51 Lee, C E and **Owens, R G** "Issues for a Psychology of Men's Health" *Journal of Health Psychology* (in press)

52 Haase, A, Prapavessis, H, and **Owens, R G** "Perfectionism, social physique anxiety and disordered eating: a comparison of male and female elite athletes" *Psychology of Sport and Exercise* 3, 2002, 209-222

53 Reeve, J, **Owens, R Glynn**, and Neimeyer, G "Using examples in repertory grids: the influence on construct elicitation" *Journal of Constructivist Psychology* **15**, 2002, 121-126

54 Mitchell, K, and **Owens, R Glynn** "National Survey of medical decisions at end of life made by New Zealand General Practitioners" *British Medical Journal* **327**, 2003, 202-203

55 Mitchell, K, and **Owens, R Glynn** "Judgements of laypersons and general practitioners on justifiability and legality of providing assistance to die to a terminally-ill patient" *Patient Education and Counselling* **54**, 2004, 15-20

56 Mitchell, K, and **Owens, R Glynn** "End-of-life decision-making by New Zealand general practitioners; a national survey" *New Zealand Medical Journal* **117**, 1-11

57 Wroe, A L, Turner, N, and **Owens, R Glynn** "Evaluation of a decision-making aid for parents regarding childhood immunization" *Health Psychology* **24**, 2005, 539-547

58 Chan, C K Y and **Owens, R G** "Perfectionism and eating disorder symptomatology in Chinese immigrants; mediating and moderating effects of ethnic identity and acculturation" *Psychology and Health* **21**, 2006, 49-63

59 **Owens, R G** and Slade, P D "So perfect it's positively harmful? Reflections on the adaptiveness of Positive and Negative Perfectionism" *Behavior Modification* **6**, 2008, 928-937

60 Chan, C K Y, Ku, Y, and **Owens, R G** "Perfectionism and eating-disorder symptomatology in Korean immigrants" *Asian Journal of Social Psychology* **13**, 2010, 293-302

61 **Owens, R Glynn** "Sometimes a case can be made for physician-assisted suicide". *Journal of Primary Health Care* **2**, 2010, 249-250

62 Oyebode, J R and **Owens, R Glynn** "Bereavement and the role of religious and cultural factors" *Bereavement Care* 32, 60-64

63 **Owens, R Glynn** "Is the trolley problem a problem?" *Journal of Primary Health Care* **3**, 2011, 74-76

64 Larsen-Barr, M, and **Owens,** R G "Trandisagnostic support and education can reduce anxiety in people diagnosed with schizophrenia spectrum disorders" *Psychosis* (in press)

65 Kent, B, Andersen, N E, and **Owens, R G** "Nurses' early experience with patient death; the results of an on-line survey of registered nurses in New Zealand" *International Journal of Nursing Studies* 2012, **49**, 1255-1265

66 Haase, A, Prapavessis, H and **Owens, R G** "Domain-specificity in perfectionism; variations across domains of life" *Personality and Individual Differences* 2012, **55**, 711-715

67 Gaab, E M, **Owens, R G** and McLeod, R "Primary caregivers' experiences living with children involved in paediatric palliative care in New Zealand" *Vulnerable Children and Youth Studies* 2012, 1-9
68 Gaab, E M, **Owens, R G**, and McLeod, R "Caregivers' estimations of their children's perceptions of death as a biological concept" *Death Studies* 2013, 1-11
69 Gaab, E M, **Owens, R G**, and McLeod, R "Primary caregivers' decisions around communicating about death with children involved in paediatric palliative care" *Journal of Hospice and Palliative Nursing* **15**, 2013, 322-329
70 Wojdylo, K, Baumann, N, Buczny, J, **Owens, G** & Kuhl, J "Work Craving: A Conceptualization and Measurement", *Basic and Applied Social Psychology* 2013, 35:6, 547-568, DOI: 10.1080/01973533.2013.840631
71 Gaab, E M, **Owens, G**, & McLeod, R "Siblings caring for and about palliative care patients" *Journal of Palliative Medicine* 2014, 17, 62-67

Other media

1 **Owens, R G**, and Naylor, F "*Communication in terminal care*" Audiovisual package produced by Napp Laboratories and University of Liverpool TV Service 1987
2 **Owens, R G** and Austen, R "*In the face of aggression*" Audiovisual package produced by Wyvern Business Training Ltd, Cambridge, 1991

"RGO2"

IN THE NEW MEXICO COURT OF APPEALS

COURT OF APPEALS OF NEW MEXICO
ALBUQUERQUE
FILED
SEP 08 2014
Wendy F Jones

KATHERINE MORRIS, M.D.,
AROOP MANGALIK, M.D., and
AJA RIGGS,

Plaintiffs-Appellees,

v. **No. 33,630**

KARI BRANDENBERG, in her
Official capacity as District Attorney
For Bernalillo County, New Mexico, and
GARY KING, in his official capacity as
Attorney General of the State of New Mexico,

Defendants-Appellants.

On Appeal from the New Mexico District Court
Second Judicial District, County of Bernalillo
District Court Judge Nan Nash

BRIEF OF AMICUS NEW MEXICO PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF THE PLAINTIFFS-APPELLEES

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This is the annexure marked **"RGO2"** referred to in the affidavit of **Richard Glynn Owens** affirmed at Auckland this day of April 2015 before me

Signature 24/04/15
A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

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STATEMENT OF COMPLIANCE

Pursuant to Rule 12-210.G NMRA 2013, this is to certify that this Amicus Brief complies with the requirements of Rule 12-201.F(3) NMRA 2014. The number of words contained in the body of the Reply Brief as defined in Rule 12-201.F(1) is 5,678 words. This word count was obtained using the Microsoft Office Word program.

Robert Schwartz

INTEREST OF AMICUS[1]

The New Mexico Psychological Association (NMPA) is the largest organization of professional doctorate-level psychologists in New Mexico and the leading source of professional standards and policy for psychologists who practice within the state. It has been established to promote quality research and the highest level of qualified professional practice in psychology, to improve the qualifications and usefulness of psychologists by upholding and maintaining the highest standards of professional ethics, conduct, education, and achievement, and to increase and diffuse psychological knowledge throughout New Mexico. N.M. Psychological Ass'n., *Constitution and Bylaws, Section 2* (2005). It is the primary authority to speak on behalf of psychologists and their patients, and those who provide related mental health services and their patients, in New Mexico, and it is concerned with assuring that the law in New Mexico permits and encourages the highest level of psychological practice.

The NMPA is committed to providing high quality mental health care to all New Mexicans. In doing so, members often provide services to those who are contemplating suicide, and to family members and friends of those who have committed suicide. Its members have also provided services to competent adults

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[1] No counsel for any party authored any part of this brief, and no person or organization outside of the amicus itself made any monetary contribution to fund the preparation or the submission of this brief. This disclosure is made pursuant to NMRA, Rule 12-215(f).

who are terminally ill and facing imminent death, and to their friends and family members. Some of these terminally ill patients are also considering asking their physicians for Aid in Dying (AID)[2] if their suffering during the dying process becomes too difficult to bear, and some of these patients have been referred to psychologists for counseling by the physicians from whom they sought AID.

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[2] In adopting the term "Aid in Dying," the New Mexico Psychological Association joins its sister organization, the Washington State Psychological Association, which has stated: "A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disrespectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals." Judith R. Gordon, *New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices*, Wash. State Psychological Ass'n. (Jan. 8, 2007), http://www.wapsych.org/resource/resmgr/Docs/New_WSPA_Policy_on_Value-Ne.docx. The term has been adopted by several other organizations and most academic writers. Even those who do not choose that terminology do not use "suicide" or "assisted suicide" to describe the AID process. See, for example, the new edition of the leading Health Law casebook, Furrow et al., *Health Law* (7th ed. 2013), which refers to "medically assisted dying."

While several years ago terms like "assisted suicide" had been used to describe a competent, terminally ill patient's decision to seek a physician's help in prescribing medication that could hasten the dying process, over the last several years responsible health care providers, lawyers, academics and others have stopped referring to this process as any form of "suicide." The general consensus is that "aid in dying" is more accurate, sensitive, and consistent with the professional literature in the field. "Aid in dying" is the better descriptive term, and it avoids presuming any sets of values. Consistent with the propriety of "aid in dying," the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine (the organization of JD-MDs), the American Student Medical Association, and the American Medical Women's Association have all recently rejected using the term "assisted suicide," mostly in favor of "aid in dying." For the most part, the only individuals and organizations continuing to refer to the practice using the word "suicide" are those who, for political, religious or philosophical reasons, advocate against it. The movement to use the neutral term "aid in dying" has only accelerated in the last few months. See D. Orentlicher, T. Pope and B. Rich, The Changing Legal Climate for Physician Aid in Dying, JAMA online (published April 14, 2014)(citing this New Mexico litigation).

Just as advocates for aid in dying now refer to it as "death with dignity," opponents of aid in dying call it "assisted suicide." Of course, no one on either side opposes dignity, and no one on either side wants someone considering suicide to go untreated or unprotected. In short, "assisted suicide" now is a pejorative term used for political purposes by those who believe it to be morally wrong.

The NMPA recognizes that if a psychologist is required to treat a patient considering AID like a patient considering suicide, that psychologist cannot possibly provide adequate care that is consistent with the psychologist's professional standard of care.

The NMPA and its members recognize that AID and suicide are fundamentally different psychological phenomena, and that these different categories of patients must be treated differently by the law for their patients to be able to get adequate psychological support at the end of life. Psychologists think of suicide as their greatest challenge, and they work tirelessly to prevent their patients from committing suicide. They also recognize that AID involves almost no substantive theoretical overlap with suicide. Being required to treat competent terminally ill patients seeking AID as potential suicide "victims" will undermine the quality of care they can provide just when dying patients need their help the most. This view of psychologists on this issue is especially important because psychologists are experts on mental health care related to suicide in this country. They are uniquely well positioned to understand the actual consequences of the determination of the issues before this Court on those who are at risk for suicide and those who seek access to aid in dying from their physicians.

The Board of the New Mexico Psychological Association, after protracted and serious discussion over several months, decided unanimously to support the Plaintiffs in this case, and to seek permission from the Court to file an amicus brief on behalf of the Plaintiffs, because of the importance of the resolution of this case to the quality practice of psychology in New Mexico.

ARGUMENT

I. SUICIDE IS FUNDAMENTALLY DIFFERENT FROM AID IN DYING. THOSE WHO CHOOSE SUICIDE REJECT LIFE; THOSE WHO CHOOSE AID IN DYING EMBRACE LIFE.

A. SUICIDAL IDEOLOGY ARISES FROM IMPAIRED COGNITION OF TEMPORARY PROBLEMS THAT ARE ACTUALLY TREATABLE; AID IN DYING, ON THE OTHER HAND, ARISES FROM ACCURATE COGNITION OF PHYSICAL CONDITIONS THAT ARE TRULY INCURABLE.

Psychologists are trained to assess suicide risk and, as a matter of course, to consider that risk in every patient. The State of New Mexico has long authorized licensed psychologists and physicians (and lately other mental health care professionals) to certify that a patient should be detained and evaluated in the event that the patient presents a risk of serious harm to him or herself. NMSA 1978 § 43-1-10(A)(4). Psychologists figure prominently in suicidology and research into the causes and prevention of suicide. *See*, *e.g.*, Edwin S. Shneidman, *The Suicidal Mind* (1998). Determining whether a patient poses a risk of suicide and how to address that risk are central to the practice of psychology in New Mexico, as elsewhere.

One substantial difference between suicidal patients and those who seek AID is that suicidal patients do not realize that their condition is amenable to treatment, and that they can overcome their urge to commit suicide. Their mental health pathology can be treated. *See* Thomas Reisch et al., *Efficacy of Crisis Intervention*, 20(2) Crisis: J. of Crisis Intervention and Suicide Prevention, 78-85 (1999). Those who seek access to AID, on the other hand, are actually suffering life-ending illnesses that cannot be cured. They have no misunderstanding of their condition, and the reason they seek access to AID is because no medical treatment can make the continuation of life possible; that is exactly what makes them terminally ill. Suicidal patients react to their misunderstood condition by applying distorted logic; those seeking AID react to their fully and correctly understood terminal condition by applying well reasoned logic that is consistent with the values that they have embraced for years or decades.[3]

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[3] David A. Pollack, M.D., psychiatrist and witness qualified by the court as an expert in end-of-life care and decision-making, provided clear, well supported and completely unrebutted testimony that "[suicide] is a despairing, lonely experience, whereas the person who requests aid in dying is doing this . . . to alleviate symptoms but, more positively, to maintain the relationships, the connections, and the sense of self being more integrated to the point where they end their life. And so it's more maintaining peace, joy, relief . . . or what you might define as happiness." 2 Tr. 94:22-25, 95:1-4. "[People who seek AID] focus[ ] on maintaining the quality of life that is something that they cherish[ ] and they want to capitalize on as much as possible in the time they have left whereas the person who is depressed and suicidal turns inward, becomes isolated." 2 Tr. 79:20-25, 80:1-2.

Suicide motivation arises from an emotional crisis which interferes with logic and planning. Thomas Joiner, *Myths About Suicide*, 39 (2010). Suicidal patients tend to be severely depressed such that they are unable to contemplate a future without the intense emotional anguish from which they currently suffer. 2 Tr. 73:9-21. Such crises may derive from loss of a loved one, a business reversal, a personal humiliation, or any number of factors. The unifying response is a misplaced cognition that the situation will never improve; that there is no hope to right the ship. In suicidal patients, negative emotion narrows cognitive focus. Joiner, *Myths About Suicide* at 34. The suicide motive is deeply irrational. The psychologist treating a suicidal patient seeks to restore reason and thus restore hope, as is reasonable for persons with a long life ahead of them.

By contrast, the problem confronting the terminally ill patient arises from an irreversible physical calamity. She or he is dying of an incurable disease. *See* 2 Tr. 73:11-13 (Dr. Pollack testifying that "suicide is a distinctly different act than requesting aid in dying. . . because the person is already in the process of dying who is requesting this."). See also 2 Tr. 119:12-15 ("suicide" should not be used to describe the acts of people "who are not psychiatrically ill and who are already in the process of dying.") For these patients, the recognition that there is no hope for future physical improvement is accurate, not irrational. To treat a mentally competent terminally ill patient who seeks access to AID to avoid unbearable precipitate sudden, unannounced, lethal and often violent acts, like suicide. They are the quintessence of irrationality and loss of personal control. The three P's analysis describes virtually every real suicide, and it suggests why we are so concerned when there is a risk of suicide.

Fifteen years of data from Oregon regarding an open practice of AID show that patients who choose AID act as a result of a careful, fully vetted deliberation, always after a period long enough to establish the enduring nature of the desire, usually in consultation with their families and other personal and religious advisors, and always after discussion with their physicians. See 2 Tr. 94:1-22, 95:1-9. This is the opposite of deficient impulse control; this is truly deliberative action. 2 Tr. 73:1-22, 74:1-16. The physician plaintiffs in this case point out that they would require a carefully reasoned, voluntary, informed and enduring request for a prescription for AID before they would consider writing one. Further, as you might expect from the self-selected group of patients who ask their doctors about aid in dying, they are carefully deliberative and well educated. Last year in Oregon and in Washington over half of those employing the Death with Dignity Acts had graduated from college, and almost all had education beyond high school. Or. Pub. Health Div., *Oregon's Death with Dignity Act 2013* (2014) *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf; Wash. State Dept. of Health, *2013*

Death With Dignity Act Rep., Exec. Summary (2013) *available at* http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf (posted February 14, 2014)(76% of those employing the Death with Dignity Act last year had at least some college). This subset of the population seeking to act in a self-determined and autonomous manner at their death is well able to understand their options and choose among them.

The question of how much suffering to bear before death arrives is intensely personal and will turn on values and beliefs an individual has developed over the course of a lifetime. Empowering the individual with control over this question preserves an essential sense of autonomy. *See* 2 Tr. 94:22-25, 95:1-4 (expert witness testifying that those who choose AID "feel less anguish, less focus about what's going to happen, so that they can then focus on what they want to do with those precious hours, days, months that they have left to use the fullest . . . in a peaceful way"). Even though progressive illness has robbed the patient of much, being empowered to deliberate and determine how this final bit of the life journey will unfold enhances the patient's mental state. *See* Kathy Cerminara and Alina Perez, *Therapeutic Death, A Look at Oregon's Law*, 6(2) Psychol. Pub. Pol'y & L. 511-518 (2000).

The collaboration between physician and patient over time reflects a deliberative, rational process, the antithesis of impulse-driven behavior. 2 Tr. 99:1-18 – 101:1-7. The nature of the deliberative process in every case of AID is made even more impressive by the fact that all of those choosing AID have made the decision to do so while in the course of regularly seeing health care providers, other than psychologists, who are treating other physical disease conditions, most often cancer, which afflicts the vast majority of those who choose AID under the Oregon statute. *See* Or. Pub. Health Div., *Oregon's Death with Dignity Act 2013* (2014). Poor impulse control is a defining characteristic of suicide; it is not present in those choosing aid in dying. AID and suicide are at the opposite extremes of the continuum of rational thought and conduct, and ought not be conflated. 2 Tr. 110:1-20 – 112:1-13.

C. SUICIDE LEAVES FAMILY MEMBERS DISTRAUGHT, OFTEN DESTROYED, AND VIRTUALLY ALWAYS EMOTIONALLY TRAUMATIZED. AID IN DYING BRINGS FAMILIES TOGETHER AND ALLOWS FAMILIES TO DEAL SUCCESSFULLY WITH GRIEF.

The act of suicide is usually lonely and alienated, leaving in its wake a distraught family. *See* Thomas Joiner, *Myths About Suicide* 123 (2010). Psychologists see countless family members who struggle to make sense of an irrational, final act planned and committed without their knowledge, support or consultation. At the least, family members feel abandoned and disempowered after a suicide. They feel utterly without control, and they also feel they failed their suicidal family member. They are also likely to feel resentment resulting in complex grief. *See* Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide*, 25(1) J. of Crisis and Suicide Prevention 12-18 (2004).

The experience of family members following AID is very different. *See* 2 Tr. 96:25, 97:1-6 (Dr. Pollack testifying that most family members of those who choose AID "have described feeling more prepared for the person's death and more at peace in relationship to it whereas those who have a sudden loss of a close person feel a lot of unfinished business, disconnected, no closure . . . and feel maybe in some ways cheated"). At the Seattle Cancer Care Alliance, families of patients who opted for AID frequently expressed gratitude after the patient obtained the prescription, regardless of whether the patient ever ingested the medication. They felt they could support their family member by supporting the decision to access AID. They referenced an important sense of patient control and family support in an uncertain situation. *See* Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 New Eng. J. Med. 1417 (2013). In these cases the patient's acquisition of some sense of control over his time and manner of death, whether the medication is ingested or not, may well have a positive emotional effect on the family, sharing in the pain and loss, as well as on the patient himself. 2 Tr. 97:1-10, 98:1-14.

There is little doubt that recognizing the patient's right to control the timing of his or her death has given Washington families greater ability to join together for support of their loved ones at that crucial moment. Similar findings in Oregon show that the family survivors of patients who choose AID do not suffer the adverse mental health impacts suffered by family members of suicide victims. *See* Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. of Pain and Symptom Management 807 (2009).

D. SUICIDAL PATIENTS WHO ARE SAVED FROM SUICIDE OFTEN GO ON TO LEAD LONG AND PRODUCTIVE LIVES, THANKFUL THAT THEIR SUICIDES WERE AVERTED. THOSE WHO ARE DENIED AID IN DYING GENERALLY LIVE ONLY A BIT LONGER, OFTEN WITH HORRIFIC SUFFERING, FRUSRATED BY THE DENIAL OF CONTROL AND AUTONOMY AT THE END OF LIFE.

As an impulse-driven event, the act of suicide irrationally aims to permanently end its victim's intense anguish by ending his biological life. Thomas Joiner, *Myths About Suicide* 7 (2010). Psychologists sometimes ruefully refer to suicide as "a permanent solution to a temporary problem," since the patient sees no hope in a circumstance where a rational person would be able to find hope. That is often the very purpose of therapy. Research into suicide shows that persons restrained from suicide by jumping off a bridge, for example, often go on to lead productive lives. In one leading study, virtually all bridge jumpers who survived recalled experiencing profound regret during the four seconds it took to reach the water. Richard Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 Suicide and Life-Threatening Behavior 1-13 (1978).

Psychologists sometimes use Reasons For Living (RFLs) as a therapy technique with suicidal patients. *See* David Jobes, *Managing Suicidal Risk* 22-23 (2006). These include plans and goals for the patient's future, family, friends, responsibilities to others, enjoyable trips, and anything else which gives the patient affirmative reasons to fight through a lethal depression. The evocation of hope can be one of the most important and central elements of healing. See C. E. Yahne, and W. R. Miller, *Evoking Hope*, in American Psychological Association, Integrating Spirituality into Treatment: Resources for Practitioners 217-233 (1999). As Dr. Chuck Elliott, a prominent Albuquerque psychologist, teaches, "It is our job to give our patients hope." If that hope can be restored and the patient saved from a suicide that would later be the source of terrible regret, the psychologist or other person who managed to do so can count that as an important success – effectively, the saving of a life.

The result of denying AID is far different. No life is saved. No suffering is averted; indeed, the patient's physical suffering will most likely last longer and perhaps grow even more horrific before the final ravages of the cancer or other disease culminate inevitably in death. The psychological suffering at being denied the autonomy to determine how much agony to endure before death arrives will often be profound. The meaning of a terminal diagnosis is that death will come soon, regardless of medical treatment. From a physiological point of view, and from the perspective of the progression of the underlying disease, it will make little difference whether a patient has access to AID; the patient is going to die soon in any case. From a psychological perspective, though, the utter and final lack of control that comes from being denied the opportunity to avoid unbearable suffering at the end of life is extremely important. It can lead to resentment, frustration, a sense of being powerless and captive of a miserable final stage of dying. The patient's frustration is also likely to extend to the patient's family members, who feel that they failed the patient when she needed their help the most and when she was helpless to act without medical assistance to end her suffering. *See* Barbara Coombs Lee and James L. Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 279-280 (2000)

When a psychologist intervenes to prevent suicide, that intervention helps his patient, both physically and mentally, in the short run and in the long run. An intervention to prevent AID will not have such a salutary effect. It will exacerbate physical pain and mental suffering in the short term, and will have no effect on the long term because the patient will die of the underlying disease whether a psychologist intervenes or not. It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

II. PSYCHOLOGISTS HAVE THE TRAINING AND ABILITY TO DETERMINE THE MENTAL CAPACITY OF TERMINALLY ILL PATIENTS TO CHOOSE AID IN DYING. THERE ARE ESTABLISHED GUIDELINES FOR ASSESSMENT OF DECISIONAL CAPACITY OF THE TERMINALLY ILL.

Virtually everybody recognizes that refusing to allow AID will force some decisionally capable and terminally ill people to endure suffering they find intolerable at the end of life. Some, however, are willing to accept this to avoid the risk that some terminally ill patients might be incorrectly determined to have decisional capacity to choose AID when, in fact, they do not have that capacity. That concern is unfounded.

The practice of psychology has developed clear standards of care for capacity determinations. Psychologists are often called upon to determine a patient's capacity under the Uniform Health Care Decisions Act, NMSA 1978 § 24-7A-11. *See also* NMSA 1978 § 24-7A-1(C) (New Mexico statutory definition of capacity). Mental health professionals in New Mexico and across the nation recognize best practices to make such determinations, and those professionals are routinely trained in making exactly this kind of determination. See James L. Werth, G. Benjamin and T. Farrenkopf, *Requests for Physician*

Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment, 6 Psych., Pub. Pol. & L. 348 (2000), and Charles H. Baron, *Competency and Common Law: Why and How Decision-Making Capacity Criteria Should be Drawn from the Capacity-Determination Process*, 6 Psych., Pub. Pol. & L. 373 (2000). In fact, over the last several years special attention has been given to the determination of decisional capacity in those who face terminal illness and, more generally, in the elderly (from whom the terminally ill are disproportionately drawn). By way of immediate example, the Amicus has offered programs to its members and other health care professionals over the last two months in Albuquerque on working with patients with dementia (September 27, 2013) and in suicide risk assessment (November 8, 2013), and in Santa Fe on dealing with depression and despair, including end of life despair (September 27, 2013). *See* New Mexico Psychological Association, *Upcoming NMPA Workshops* (listing a current schedule of the active NMPA education program touching on these issues) *available at* ww.nmpsychology.org/displaycommon.cfm?an=1&subarticlenbr=25. Where they have been called upon to do so, professional mental health associations have developed nationally respected standards specifically for assessing a person's capacity to choose AID. *See, e.g.*, Washington State Psychological Association, *The Washington Death with Dignity Act: WSPA Guidelines For Mental Health*

Professionals (2010) *available at* http://www.wapsych.org/resource/resmgr/Docs/ DWD_Guidelines_6-3-09.pdf. *See also* Tony Farrenkopf and James Bryan, *Psychological Consultation Under Oregon's 1994 Death With Dignity Act: Ethics and Procedures*, 30(3) Prof. Psychol.: Research and Practice, 245-249 (1999). Dr Pollack spent considerable time on the witness stand describing the process that is routinely used by psychiatrists and psychologists in making these determinations of capacity, and explaining the source of standards of care for doing so. See 2 Tr. 74:16 et seq.

A mental health professional will not always be required to evaluate the capacity of a terminally patient who chooses AID, of course. Under the Uniform Health Care Decisions Act, a patient is presumed to have decisional capacity to make a health care decision (like choosing AID, if her physician believes that is among her appropriate choices). NMSA 1978 § 24-7A-11(B). If there is any question, though, physicians can consult with a mental health professional to avoid any uncertainty about the patient's capacity. See NMSA 1978 § 24-7A-11(C). As the experience in Oregon and Washington suggests, physicians occasionally do so. There may have been a time when mental health professionals were not trained to make such determinations in the terminally ill, and there was a time when those professionals had no professional standards to apply in making those decisions, but that time is long past. Making capacity determinations at the end of life is now a regular function of psychologists and other mental health professionals. *See* 2. Tr. 74:1-20 – 76:1-10, 103:15-19, 104:2 (expert testifying that "it is the same circumstance" when a person is terminally ill and mentally competent to make a decision to end a life-sustaining treatment and when a person is terminally ill and mentally competent to make a decision to choose aid in dying). There are adequate tools for professionals to make these determinations, and these professionals are well trained to do so.

III. PSYCHOLOGISTS HAVE SPECIAL LEGAL AND ETHICAL OBLIGATIONS WITH REGARD TO SUICIDE. IT WOULD UNDERMINE THE WORK OF PSYCHOLOGISTS TO REQUIRE THEM TO TREAT AID IN DYING AS SUICIDE, AND IT WOULD DESTROY PSYCHOLOGISTS' ABILITY TO COUNSEL TERMINALLY ILL PATIENTS WHEN THEIR ASSISTANCE IS MOST DESPERATELY NEEDED.

It is extremely important that psychologists be able to treat suicidal patients and prevent suicides. It is equally important for psychologists to be able to counsel family members and friends of those who have committed suicide, or are threatening to do so. As a matter of law, psychologists and other mental health workers are permitted to issue certificates authorizing a law enforcement officer to detain by force and hospitalize a patient who is threatening suicide, and the standard of care requires that psychologists issue such certificates when the threat is one of imminent harm. A psychologist would be at risk of civil liability to both the patient and to others, including the patient's family members, if the psychologist were to breach this legal obligation.

At the same time, psychologists also have a duty to provide counseling to those who are approaching death due to terminal illness and to their family members. Many physicians – oncologists, geriatricians and others – refer their patients to mental health providers for counseling when they are diagnosed as terminally ill. In order to provide adequate care and support to these patients, a psychologist needs to be able to respond appropriately to a patient's mental state and address their issues with flexibility and with respect for the values, beliefs and physical situation of the patient.

It would be inappropriately condescending and it would undermine the psychologist-patient relationship for a mental health professional to treat a rational and entirely non-pathological decision of a patient to inquire into AID as an expression of suicidal ideation. Treating the decision to inquire about AID the same as one to ruminate about suicide would require application of an entirely inappropriate form of analysis and counseling. *See* 2 Tr 91:11-23 Dr. Pollack testifying that "it would be really hard . . . on a psychiatric basis" to say that a person who is seeking to end life-sustaining treatment, just as a person seeking AID, is endangering him or herself such that the person needs to be committed). The standard of care for treating a suicidal patient would require issuance of a certificate which would authorize a law enforcement officer to detain the dying patient who was considering AID. This would utterly and completely destroy the trust necessary to make the psychologist-patient relationship useful, and, as a practical matter, it would end the psychologist-patient relationship, thus depriving the patient of an opportunity to benefit from the professional knowledge of the psychologist. Further, requiring psychologists to treat AID as suicide would discourage oncologists and others from referring their patients for mental health services, and it would discourage patients from seeking out mental health services on their own as well.

The practice of good professional psychology in New Mexico requires that the law recognize the fundamental distinction between AID and suicide, and that the law recognize that AID is not a form of suicide.

IV. IN BALANCING STATE INTERESTS AGAINST A PATIENT'S LIBERTY INTEREST IN DECISIONMAKING AT THE END OF LIFE, NO WEIGHT SHOULD BE ACCORDED ANY ALLEGED STATE INTEREST IN PROLONGING DEATH OR PREVENTING AID IN DYING.

Applying strict scrutiny analysis in this case, the trial court determined that "the right of a competent, terminally ill patient to choose aid in dying" was a fundamental liberty interest that must be weighed against countervailing state interests to determine whether there was a sufficiently "compelling state interest" to limit that right under the New Mexico Constitution. RP 0217-0229. If this court were to apply the lower intermediate level of scrutiny in this case, it would be required to weigh the important interest of competent, terminally ill patients in seeking amelioration of their final suffering against any asserted state interests to determine if the state action was substantially related to an important governmental interest. Even if the court were to apply the lowest level of constitutional scrutiny, it must find that the state has acted in furtherance of a legitimate state interest for that state action to comport with the New Mexico Constitution. See *Trujillo v. City of Albuquerque*, 1998-NMSC-031, par. 15, 125 N.M. 721, *Marrujo v. N.M. State Hwy. Transp. Dep't*, 1994-NMSC-116, par. 11, 118 N.M. 753 and *ACLU of NM v. City of Albuquerque*, 2006-NMCA-078, par. 19, 139 N.M. 761.

The New Mexico Psychological Association has concluded that the interest of individual patients in choosing how much suffering they can tolerate at the end of life should be treated as a fundamental liberty interest. For the reasons articulated above, it is an extraordinarily personal and individual matter, and the psychological and emotional consequences of being forced by the state to undergo unbearable suffering that could be avoided by appropriate and available medical intervention is cruel to both the patient and to those family members and others who care about the patient.

As a consequence of its deep concern about the problems caused by suicide in this society, the New Mexico Psychological Association also believes that the result of the constitutional balancing would be the same without regard to which level of scrutiny were applied. The primary countervailing state interests raised by the State in this case are the interest in preventing suicide, the interest in preserving life, and the interest in protecting innocent third parties, like family members of those who might choose AID. As the evidence introduced at the trial court indicates, however, even if AID were found to constitute "suicide," none of the reasons for the state to intervene to protect its citizens from suicide are implicated when this form of medical care is at issue. Similarly, while the amicus agrees that New Mexico has an interest in preserving life, the evidence shows that prohibiting AID does not ultimately protect any human life. In fact, it is the inability to control final suffering the patient can foresee – not AID -- that is likely to undermine a patient's will to continue to live. Finally, there is no evidence whatsoever that AID has any adverse effect on any family members or other innocent third parties. Indeed, quite the opposite appears to be true: it is the inability to help one who is suffering, and who could be relieved through AID, that leads to devastating psychological trauma for those who truly care for the dying patient.

CONCLUSION

For the reasons stated above, the Amicus New Mexico Psychological Association requests that the Court grant the Plaintiffs the relief sought in their Complaint in this case.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that I served the Brief of Amicus New Mexico Psychological Association in Support of the Plaintiffs-Appellees on all counsel of record listed below by Regular U.S. Mail on the 8th day of September, 2014.

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"RGO3"

On the 30th day of JUNE, 2014, the Official Court Reporter for the Second Judicial District filed in the Office of the Clerk of the Court a Transcript of Proceedings on Appeal to the NEW MEXICO COURT OF APPEALS.

SECOND JUDICIAL DISTRICT COURT
COUNTY OF BERNALILLO
STATE OF NEW MEXICO

Case No. D-202-CV-2012-02909

COA No. 33,630

This is the annexure marked **"RGO3"** referred to in the affidavit of **Richard Glynn Owens** affirmed at Auckland this day of April 2015 before me

Signature .... 24/04/15 ....

A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

KATHERINE MORRIS, M.D.,
AROOP MANGALIK, M.D., and
AJA RIGGS,

Plaintiffs,

vs.

VOLUME 2 OF 3

KARI BRANDENBURG, in her official capacity as District Attorney for Bernalillo County, New Mexico, and GARY KING, in his official capacity as Attorney General of the State of New Mexico,

Defendants.

TRANSCRIPT OF PROCEEDINGS

On the 11th day of December, 2013, at approximately 11:04 a.m., this matter came on for hearing in a BENCH TRIAL before the HONORABLE NAN G. NASH, DIVISION XVII, Judge of the Second Judicial District Court, State of New Mexico.

moment in my treatment, we were all about, let's try to address this, get through the treatment. There's still some hope. Let's focus on that.

THE COURT: Assuming that your cancer returns and if you had the ability to make the choice, what would you consider that you were doing?

THE WITNESS: If I had the ability --

THE COURT: The ability to get a prescription, what would you consider that you were doing?

THE WITNESS: If I used the prescription?

THE COURT: Yes.

THE WITNESS: I would consider it to be ending my suffering.

THE COURT: During your treatment, were you prescribed other drugs to assist with your suffering?

THE WITNESS: There were so many -- sorry. There are so many prescriptions. I'm trying to think if I was prescribed pain relief in particular. Well, certainly with the surgery and then with chemo, several different medications that would help with some of the effects of chemo that were difficult.

THE COURT: Those are all my questions. Thank you for your testimony. You may step down.

Call your next witness, please.

MS. SMITH: Your Honor, I would call Dr. David

Pollack.

THE COURT: Would you raise your right hand.

(NOTE: Witness is duly sworn.)

THE COURT: Go ahead and be seated.

DAVID A. POLLACK, M.D.

(being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. SMITH

Q. Please state your name.

A. My name is David Pollack.

Q. And what is your profession?

A. I'm a physician and my specialty is in psychiatry.

Q. How long have you been practicing as a psychiatrist?

A. I shudder to say, 40 years.

Q. I would like to discuss a little bit of your education. Where did you receive your Bachelor's Degree?

A. Northwestern University in Evansville, Illinois.

Q. And what year did you receive that degree?

A. 1969.

Q. Where did you attend medical school?

A. University of Oklahoma. Oklahoma Health Sciences Center, I think is what it was called, in Oklahoma City.

Q. And what year did you graduate?

A. 1973.

Q. And where did you do your residency?

A. Oregon Health and Science University in Portland.

Q. And what sort of residency training did you receive?
A. It was a general adult psychiatry residency program.
Q. When did you become licensed as a physician?
A. Somewhere in that time, between '73 and '76. I had a provisional license during my residency. Before I finished the residency, I got my official medical license.
Q. And in what state?
A. For the state of Oregon.
Q. Are you Board-certified?
A. Yes, I am, in psychiatry and neurology. It's a package deal.
Q. Do you have any other distinctions in your certification that might be considered important?
A. Well, my title -- my academic title is Professor for Public Policy, and so I spend a lot of time on policy-related issues, as well as clinical practice and teaching based at the university. And among other things, I have done policy work that relates to this particular topic of aid in dying. I have done policy work at different levels -- local, state, national. I did a health policy fellowship and worked in the U.S. Senate for a year in 1999 in the office of Senator Kennedy, during which time I also participated in some activities that had to do with looking at the experience with Oregon law. I have an appointment at the University as the senior scholar in the Center for Ethics and Healthcare at

Oregon Health and Science University. I teach healthcare organizational ethics, as well as addressing ethical issues in training with medical students and psychiatry residents and other mental health professionals.

Q. In your classes that you teach, do you teach about end-of-life care?

A. I do. Certainly the subject comes up in a number of contexts, as I mentioned, in teaching medical students, in doing clinical work, in doing training with residents in psychiatry. And we have a health management MBA program at OHSU. And in the context of that program, it's actually both an MBA and a Master's of Science tracks that people have. We have a healthcare organizational ethics course in which we address end-of-life issues and some other conflicts that might occur in healthcare settings and how one goes about making responsible, ethical decisions around controversial and difficult topics.

Q. In your work do you also treat patients?

A. Yes, I do.

Q. And were there times in your career where you treated patients more frequently?

A. Yes. Certainly the first decade or two or three of my career I did mostly clinical work. And then that I had to blend, as many people as they advance in their careers in healthcare, a variety of administrative, policy, teaching, as well as clinical work, as well as doing some consultation. I'm not a direct researcher, but I consult with people who do certain kinds of health services research.

Q. Have you written any published works on the subject of aid in dying?

A. Yes, I have. At least two things that I have co-authored. One was a report that was done for the Oregon Psychiatric Association that I and several of my colleagues put together as a position paper on what are some of the issues that relate to the psychiatric aspects of aid in dying. The other paper was published in a journal called *The Community Mental Health Journal*, and it was addressing -- this actually was published in 1998, and it was not long after -- we wrote it not long after the initiative had passed in the state, and our Department of Psychiatry at the University, being the only academic health center, we started to raise the question: Well, if this is now law, how do we as psychiatrists address this part of the law? It includes if the attending physician requests an evaluation of the person's mental status to determine if their judgment is affected by psychiatric conditions, such as evaluations to be conducted, and the psychiatrists and psychologists are the eligible professionals to do that kind of evaluation.

So one of the things we wanted to do was outline what made sense as the right kind of evaluation to do in these circumstances and then to address some ancillary issues related to that including, what are the other roles that psychiatrists and other mental health professionals may have vis-a-vis the patient, the family, the treating team in consulting with them and evaluating a number of things, helping to provide consultation to help them go through whatever the process is that they're going through. And included in that paper, in retrospect, I realize that we may have been the first ones to recommend that the terminology be shifted from "assisted suicide" to "aid in dying" or "physician aid in dying."

Q. And why is it that you thought that that shift from the terminology was important?

A. Well, this requires saying a few things about what the context is. If, as the law says, someone who is eligible in Oregon for requesting aid in dying, they have to be -- the probability of their death within six months has to be established by, I believe, a physician and a second physician to give a confirming opinion of that. So the question is not whether or not the person is going to die, but that they are going to die.

And then one needs to think about, well, what are the different types of death that humans go through? And there can be sudden death or more chronic death, deaths that may involve some deterioration and some that may involve a much more prolonged, lingering deterioration. And the level of functioning of the individual that is maintained during that process of dying may vary. Some people may maintain an ability to function in, what we say, an integrated way, in an integrated self throughout that whole course. Others deteriorate and lose either bodily functions or cognitive or other emotional or psychological functions, as well as coming in and out of consciousness.

And, therefore, when one is thinking about the concept of suicide versus aid in dying, I think it's important to distinguish that suicide is a distinctly different act than requesting aid in dying; A, because the person is already in the process of dying who is requesting this. The person who is committing suicide, who has a psychiatric condition, usually it's a form of depression, but sometimes it's other psychiatric conditions that may involve psychotic symptoms unrelated to being depressed. In those cases, the act of suicide is usually impulsive. It's solitary. It's done without consulting or even allowing friends or family to know about the act, whereas with aid in dying, a person goes through a deliberative process.

In fact, it requires at least two visits with a physician to have that innocence confirmed and to make sure that the person wants to do that. And it almost always involves the person discussing this with their family and friends and the support network that they have, and to do so in a way that they can establish that this is a choice that they are making out of their own free will, and to alleviate symptoms or suffering, and to maintain a quality of life and a level of integrity of themselves, their ego identity, if you will, and their functioning as long as possible. And their purpose usually in choosing to end their life at one level, in kind of an overt or manifest level, is to alleviate symptoms, to spare others from the burden of watching them dwindle away or be a shell of their former self or to feel like they are in control, have some autonomy and some control over the way that they die.

The basic existential issue generally beneath that is the desire to maintain the integrity of themselves; that they are connected to others, as Ms. Riggs said, and that they have the ability to feel together and as a whole person.

Q. One of the requirements of Oregon's Death With Dignity Act is that somebody be considered mentally competent. Do you have experience evaluating competency?

A. Yes, I do. It's important to clarify that in the process of doing an evaluation -- and part of what we try to explain in that paper I mentioned, it was both to say, Here's the kind of evaluation that one should do, but also that we need to make sure that we're training our future psychiatrists and psychologists that this is the way to do it, so we have an organized way of making sure we have competent people doing the examinations and evaluations.

There are several things that one would want to clarify. One is simply what the person's condition is, whether they actually have a terminal illness, you know. So this involves consulting with the attending physician and finding out what the status of things is and then finding out more about what their reasons are, generally, in a process that a skilled clinician interviewer would do that doesn't suggest ideas or reasons but tries to elicit from the patient why he or she is wishing to request aid in dying. And then it's important to establish whether the person has some kind of psychiatric condition that might be interfering with their judgment or contributing to their making this choice in a way that would be perceived as not allowing them to have really free choice; that they are being driven more by their psychological stress and that that psychological stress is more than just the conditions that I'm talking about in terms of the symptoms that they are experiencing, but some profound psychological condition, like a major mood disorder -- major depression, bipolar disorder, or even a psychotic illness -- that would need to be identified as to whether they have it or if they have a history of these kinds of psychiatric conditions that usually emerge early in one's adult life. Adolescence to early adult life, those kinds of conditions would and generally seem to be present, even if they are recurrent.

And then even if someone has a psychiatric illness or condition, to make sure that if they have that condition, that it's not active at the present time and contributing to the judgment that they're trying to make. So part of my point is one can have a co-morbid psychiatric condition and that doesn't operate to rule out the possibility that their decision-making in regard to aid in dying is not legitimate and consistent with what the law expects.

Q. Doctor, let me touch just a little bit --

A. Sure.

Q. -- on some of what you said.

A. Sure.

Q. So is it common for people who are terminally ill to be depressed?

A. It is common for people who have been given bad news of one kind or another, even if you've been told that you have a chronic illness that you didn't think you were going to have, to be disappointed, to go through various stages of emotional reactions to that -- either disbelief or anger or depression -- but at some point going through a process that was originally described by Elizabeth Kübler-Ross that associates with the stages of how one deals with bad news. And she initially focused mainly on the process of dying, of reaching a stage of acceptance and recognizing, This is the reality of where I am in my life and I go on from here. Some people get stuck in some of those stages, in either denial or in depression or in anger, and they may need help to work through that. But it's not common that people stay stuck in those stages, and so it's not surprising that someone would feel sadness, but may not meet the criteria for a clinical depression in the process of getting that news.

Q. So how do you sort out, when you're doing -- when you're evaluating somebody, how do you sort out between somebody who is working through a situation where they are either depressed by their diagnosis versus somebody whose desire for aid in dying is coming from a place that is influenced by a mental disorder?

A. There are a couple things about that. One, just looking at the symptoms and the criteria for the diagnosis of major depressive disorder and seeing whether the person meets those criteria, the two main symptoms or conditional issues are: Does the person have a prolonged experience of feeling sad, down, blue, thoughts of death or thoughts of wanting to kill themselves that lasts for at least two weeks or longer, or a diminishing of their interests in life or inability to take pleasure in life, something we call "anhedonia," coupled with certain other symptoms. There's psycho-biological symptoms that may involve difficulty with sleep or appetite that are separate from the symptoms that may be associated, say, with a cancer or with the physical illness that a person may also have, and often morbid preoccupation with suicide or a wish to die can sometimes take on delusional proportions.

Like the person may have a lot of self-incrimination: I'm a bad person or I have something bad inside of me or this is my fate for having done bad things at some point in my life. A psychiatrist or a psychologist can usually distinguish those from more rational reasons for the person to feel sad. So it's out of proportion, some of the things they are experiencing, to the reality of what their life is.

Q. And so when you're looking at some of those criteria, how would you distinguish that person seeking -- person seeking aid in dying, who might have some of those physiological symptoms that you mentioned because, you know, they might have fatigue or inability to eat?

A. That's right.

Q. So do you sort through that?

A. I think part of it in this case -- well, one of the things I should have said earlier is, in distinguishing suicide from aid in dying, there's two universes, I guess, of people, two cohorts of people you want to think about: people who have a terminal illness and people who don't have a terminal illness. Of those who don't have a terminal illness and have depression and are feeling suicidal, it's kind of not an issue. Of those who have a terminal illness and wish to commit suicide versus those who wish to pursue aid in dying, there are distinctly different ways they present.

Part of it has to do with their motives, what they are saying they want to do. And it's often along the lines of what we heard from Ms. Riggs, or what I was describing to you earlier, about wanting to avoid the pain and suffering that they inevitably anticipate experiencing or that they have already experienced and don't want to experience again; or the hassle, burden associated with the ongoing medical interventions that are required to maintain the quality of life that they've been experiencing up until then; that they're just tired of the chemotherapy or the radiation or being plugged into things or having to have so many doctor visits or having to go to the hospital and having procedures when they would rather be spending the precious time they have left with their loved ones and the people they care about or doing things that they care about.

In other words, they're focused on maintaining the quality of life that is something that they cherish and they want to capitalize on as much as possible in the time they have left whereas the person who is depressed and suicidal turns inward, becomes isolated, even if they have people caring about them. They are less approachable and they are more morbid and less reconcilable in terms of these stages I was talking about.

Q. One of the -- now, you talked about the criteria for diagnosing depression as one of the tools that can be used to make these distinctions. Are these sorts of guidelines available to any qualified psychiatrist?

A. They are available to everyone. The DSM, which is the *Diagnostic and Statistical Manual* of the American Psychiatric Association, is widely available electronically, as well as in hard copy. Physicians often turn to it, not just psychiatrists and other mental health professionals. When I teach my family medicine residents that I work with in the clinical work I do, we look at the DSM to look at the diagnoses of people that we're evaluating together. So it's a resource that is available, and now we have the new version, the DSM V that just came out in May. So it's widely available.

Q. And so this is something that a qualified -- and any qualified psychologist could evaluate, not just someone operating under the statute in Oregon?

A. Absolutely. I would imagine any psychiatrist, most psychiatrists, most psychologists would be able to -- with the skills they have in their regular practice, would be able to evaluate. They may have to learn something more about the process that's associated with end-of-life issues, but that's not that big a stretch for most of them.

Q. Now, you also mentioned some other kinds of mental health disorders, not just depression, and that -- and explain to me how that kind of mental health disorder could operate on a person who is seeking aid in dying.

A. Well, there are a number psychiatric -- classes of psychiatric illnesses, one of which is called "mood disorders." Mood disorders include depressive disorders, where the person mainly experiences depression as the change in their mood from being okay; and there are other folks who have what we call "bipolar disorder," where they can experience either depressive and/or manic or hypomanic mood swing, meaning elevated mood. And sometimes that manic or hypomanic mood elevation can have psychotic proportions to it, where they can get out of touch with reality and lose control in terms of some of their behavior, become very impulsive, spend a lot of money, stay up late at night because they are ambitious and eager, even though it may not make sense to people.

Similarly, people who have major mood disorders, either major depression or bipolar disorder, where they have a depressive mood swing, those can, as I alluded to earlier, have psychotic dimensions to them for some folks, where they can have delusions of a terrible illness that they're having, or that they're being punished by God for some crime or sin or some terrible thing they did, or that they may project outward onto someone or something outside of them these negative thoughts or feelings. So they may believe that, say, the FBI or the CIA is after them, or that they have done something terrible, or that they have somehow contracted a terrible disease like HIV/AIDS, even though they haven't exposed themselves to risks like that. So there are a number of ways that can manifest. So that's one thing, mood disorders.

Another is other psychotic illnesses, the most common of which is other schizophrenic disorders. And sometimes people who have schizophrenic disorders can become discouraged, despondent in relation to the course of their life not working out as they or their parents or family have thought it would, and they may either impulsively or in some kind of deliberate way end their lives as well.

Q. And so if somebody has a history of any of those sorts of mental disorders, how would you -- how would you make sure that they were not operating under those, other than the depression which we discussed?

A. In doing a standard psychological or psychiatric evaluation, one would make inquiries about the kind of symptoms the person has had, would inquire more explicitly about, "Have you had these kinds of experiences?" and be observing for nonverbal behavior and other things that might be evidence of that kind of condition.

In addition, in doing this kind of evaluation, it's important to get collateral information, if at all possible, from family or other people that the person says, "Yes, it's okay to talk," obviously respecting their rights and getting their permission, but to talk to other people who may be involved in their support system to find out what they think about what's going on, what their past history has been and so forth.

Q. Are there some people who have their history with mental illness and their -- would make them never an appropriate candidate for aid in dying?

A. Oh, sure. There are people who may, because of the nature of the psychiatric illness they have -- there are a few that may never -- there are a number that intermittently may not be able to, because of having a psychotic process going on, in effect, may render them unable to provide informed consent.

Q. And are there some people who have a history of an illness who, despite this history, may be able to make a rational decision for aid in dying?

A. Absolutely. I alluded to that earlier. Simply the fact that someone has a history of, or even a current psychiatric condition, should not be sufficient as the only evidence that one would use to determine whether or not they are eligible to use aid in dying. If after a thorough evaluation it is shown that this person's condition is under control, they're on medications, or they're in psychotherapy and the types of symptoms they are having have to do with their psychiatric condition, have no bearing on and are minor in relation to the other reasons they are articulating for their wish to request aid in dying, in my view, it's not only appropriate to do that, it would be unjust to deny them the opportunity, if they've met the criteria the same as anyone else.

Q. Now, have you ever done an evaluation of somebody who was seeking aid in dying?

A. Yes, I have.

Q. And can you explain a little bit about what happened.

A. This was a patient who was referred to me by -- let me explain the context. I work -- the clinical work I do now and I've been doing for the last four? -- yeah, four years at the university has been providing consultation in two family medicine clinics that the university operates. And I do evaluations of patients that are referred who have more complex presentations, and so the primary care providers request me to evaluate them, do a report, give them recommendations.

And I got a request from an attending physician of a patient who was at this particular clinic about this

A. Well, the kind of categories of people who are less advantaged in some way, either less education or some ethnic or cultural minority or people of a lower socioeconomic status. Some people think women or people who are older or younger, you know, certain age groups, might put them in a more vulnerable position to be discriminated against or to be influenced or exploited. And so one has to be, in particular, alert to those factors playing in a case like this, and to make sure, doubly sure, that that's not going on.

THE COURT: I need a clarification. So if I'm understanding your testimony correctly, you or a similarly-situated colleague only get called in to do this sort of evaluation if there is some question about the person with a prior -- or a history or current psychiatric condition; correct? You don't do it -- this is not done for every --

THE WITNESS: That's correct.

THE COURT: Okay. And so what I'm assuming you're describing is sort of the standard of practice for making this determination if their choice is voluntary.

THE WITNESS: That is correct.

THE COURT: Do you have an understanding as to whether those tools for determining whether the process is voluntary are applied when the doctor, the oncologist or other treating physician, is discussing the choice with the patient?

THE WITNESS: Yes. If I may expound on this?

THE COURT: And does that take you totally off track?

MS. SMITH: Go right ahead.

THE WITNESS: I think this is consistent with what you were asking. In the law in Oregon it doesn't require that every person requesting aid in dying have a psychiatric evaluation.

THE COURT: Okay.

THE WITNESS: It requires the attending physician to determine whether that's necessary, and it's up to the attending physician to decide whether they think there is some question. And it's not necessarily, does this person have a past history, but whether they have any question that there is some mental or psychological factor that may be operating that would interfere with that person's judgment in making this request.

Now, the reason it isn't everyone is partly what I saying earlier and partly related to what Dr. Morris has probably described and probably what Ms. Riggs' physicians have described. The process of taking care of someone who has a terminal illness involves a longitudinal experience and the relationship the physician has with that person and the training that all physicians hopefully get in being able to evaluate their patients in terms of whether there is something going on emotionally or psychologically that would raise concerns. It may not be such that they have the expertise to accurately and definitively diagnose what psychiatric condition they have, but they certainly have the ability to determine whether there is something going on emotionally or psychologically that may need further clarification.

Q. (BY MS. SMITH) And this is based on the fact that this is an ongoing, long relationship where they get to know this patient?

A. Based on that, the fact that there's a longstanding or at least a continuous relationship with that patient, and that the physician has received sufficient training in his or her medical school and residency and clinical experience beyond that to be capable to make those kinds of determinations.

Q. And so when -- are there other situations that arise outside of aid in dying where physicians must determine whether this person -- whether a person is competent to make these kinds of decisions?

A. All the time.

Q. Can you --

A. This happens in clinical situations where people have, for example, renal dialysis. Somebody's got kidney disease, chronic kidney failure and they have to go through dialysis every week or two weeks. At some point the patient says, "I don't want this anymore." They are not requesting aid in dying. They are saying, "I refuse to take this treatment." Or I just saw in the newest episode of *Treme* last night, one of the characters in *Treme* has cancer and he has said at this point, "I don't want the chemotherapy anymore." And his family is kind of mixed.

So it happens in those kinds of contexts where someone is either refusing treatment and the physician has to decide: Is this something that is a result of the person having a psychiatric illness that may require them having an evaluation to determine if the psychiatric illness is causing them to put themselves at risk and possibly leaning to what we call a "civil commitment," where you would involuntarily treat someone? So in the hospital at the university or other hospitals, a lot of times psychiatric consultations are requests from, say, the transplant service or the renal dialysis unit or certain other medical units when there is some question of someone refusing treatment.

THE COURT: In those situations, is it statutorily required, as it is in this situation? Do you know the answer to that question?

THE WITNESS: It's not statutorily required that they request a psychiatric evaluation. It is statutorily required that the physician at least make a determination if they think the person has a mental illness. It varies from state to state, but in most states there has to be some evidence that they believe the person has mental illness and because of that illness they are either unable to care for their own basic needs or they're endangering themselves or someone else. And sometimes people interpret in the medical context, this person, by refusing dialysis, is endangering themself. So we may get a request from someone and when you talk to that patient and they're saying, "Look, I know what I'm doing, and I'm just -- I'm tired of this. I'm not depressed. I just want to stop the dialysis." And it's really hard, I think, on a psychiatric basis to say, "This person needs to be committed."

Q. (BY MS. SMITH) And knowing the consequences of that action --

A. Yes.

Q. -- refusing life-sustaining treatment, consequences of that can be the end of somebody's life; correct?

A. That's correct.

Q. Just as in aid in dying?

A. Yes. Just as it is for -- as you were talking earlier about removing a feeding tube or someone simply saying, "I'm not going to take any more liquids."

Q. Now, let me try to come back to a patient that you had who had a, I think as you put it, a "co-morbid mental disorder." So what did you -- after meeting with this patient, with his family, alone and with family members, what did you determine?

A. I determined that in spite of the fact that he had a coexisting psychiatric condition that had been a problem at times in the past, he was under sufficient control at the present time; that it wasn't factoring into his request or the decision-making process that he was using to make the request for aid in dying; and that there was no reason to, on a psychiatric basis, prevent him from having that option.

Q. Now, another possible motivation for physician-aid in dying might be somebody has uncontrolled pain or symptoms; is this correct?

A. That's correct.

Q. And if you were evaluating somebody who said this is the reason they were seeking aid in dying, would you want to know more?

A. Well, one thing I would want to know is, in talking with their attending physician or their treatment team, what is it they have done? What are the other options? Are there, indeed, other options for this person to relieve the pain or other debilitating symptoms they are experiencing? The person simply saying, "I'm having too much suffering," may not be sufficient to convince me that they are at the point where they shouldn't have to take anything else. So finding out from their physician what else has been offered, and then if those proposed options, treatment options are not excessively intrusive or something that the person would, if it was explained to them, perceive to be, "Okay, I can tolerate that," then we would say, "Well, let's wait and see what happens as you go through that."

But if you determine that, in spite of whatever treatment they have done, they are really at a point where they can only provide treatment that would compromise the person's ability to maintain the integrity of themselves -- so, for example, the palliative sedation you were talking to Dr. Morris about earlier. If there's an ambivalence one might feel about that in terms of, "I'm going to be compromised in terms of my ability to remain connected, alert," some people, before getting to that point, might elect to use the aid-in-dying option.

Q. One of the things that you've mentioned, there was a difference between suicide and aid in dying, was the nature of the act being impulsive or isolated. Can you elaborate a little on that.

A. Most people who commit suicide do it without informing other people. They do it, generally, impulsively. It's important to qualify. There are people who make suicide attempts where their intention is really to get attention and to get help. And it's a different -- we talk about the level of lethality in suicide attempts and suicidal intention. Not all suicide attempts are alike. But those who make suicide attempts where they're really intending to kill themselves are usually doing it in an isolated way. They feel some psychological isolation. They feel shame or guilt or anger or misunderstood, something like that, that separates them from others, and they feel either a fear of their family members or close connections to them knowing about what their intention is because they think they'll just put them in the hospital or they won't understand.

And they also are not thinking a whole lot about what the consequences would be. Even though sometimes they say, I'm not, it's going to hurt -- "I wouldn't kill myself because it would hurt other people," sometimes people get to a point where it's, "I don't care anymore," and it's a disconnected experience. And it is usually, as I said, impulsive, sudden, rather than something that in rarer cases is thought out and planned in a more detailed way.

Q. And how is this different from aid in dying?

A. It's a despairing, lonely experience whereas the person who requests aid in dying is doing this generally for the reasons I said earlier, to alleviate symptoms but, more positively, to maintain the relationships, the connections, and the sense of self being more integrated to the point where they end their life. And so it's more maintaining peace, joy, relief, something like that, or what you might define as happiness. I think one of the people in that *To Die in Oregon* mentions, "I'm happy now." So happiness is an important thing. And, you know, Freud described the way -- the purpose of living and being happy is to work and to love. So at some point people feel that is so compromised that they can't continue.

Q. What is the psychological effect on people who are prescribed -- who receive prescription medication for physician aid in dying?

A. It's generally a sense of relief that, I have this option, Plan B, if you will; that if the course of my dying goes okay, I mean, if I'm able to maintain that sense of feeling okay, just as Ms. Riggs said, I don't want to die. But if at some point things really deteriorate and I feel like I'm losing my, either bodily functions or my ability to be connected to others, then I will take it. So there's a sense of "in case of emergency, break glass." I've got this metaphorical fire extinguisher here I can use. That's more or less what it's like. And people then feel less anguish, less focus about what's going to happen, so that they can then focus on what they want to do with those precious hours, days, months that they have left to use to the fullest in terms of relating to other people, thinking about what they have enjoyed in their lives, visiting places that they've enjoyed, doing activities, whether it's artistic or reading or their own professional work, whatever it is, in a peaceful way.

Q. One of the other differences you mentioned between suicide and physician aid in dying is the consequences of physician aid in dying on survivors.

A. Yes.

Q. Can you explain that.

A. Well, in the context of suicide, because it's isolated and often a surprise, the family members and others who know this person go through a surprise, usually shock and disbelief or anger, a whole set of emotional reactions, a lot of which involve, "Why didn't you tell me?" Or, "We could have done something." I wish we" -- reflecting a lack of connection between the person who committed suicide and the others who cared about, or maybe didn't care about, you in a different context.

With the person requesting aid in dying, those who are close to him or her go through this process. Even though they may have different opinions, if they can come to a position of, "My respect of your choice actually trumps whatever I would have done or what I would have preferred and, therefore, I'm going to go through this with you," most people who've gone through that process have described feeling more prepared for the person's death and more at peace in relationship to it whereas those who have a sudden loss of a close person feel a lot of unfinished business, disconnected, no closure, psychological closure, if you will, on their relationship and feel maybe in some ways cheated.

THE COURT: I'm assuming when you say "most persons," you're testifying from the basis of a study that has been done?

THE WITNESS: Yes, both in terms of clinical observations in my own experience, but also there's one study, in particular, that was done looking at the reactions of family members of persons who have gone through aid in dying, those who had received the medication or -- either those who had requested aid in dying and either had the medication and took it, or had the medication and didn't take it, as well as I think those who had requested it but never actually chose to take the prescription yet, but they had gone through that process and knew they had that option, versus a control group of people who had similar terminal illnesses -- I think it was ALS and certain kinds of cancer -- who didn't go through the --

THE COURT: Okay.

THE WITNESS: -- aid in dying request, and then they studied those family members to find out what similarities and differences there were in them. So in appropriate clinical research approaches they had matched groups that were roughly the same in terms of demographics and age and other characteristics, and then they looked at what kinds of mental health problems either group had and other questions that they asked them about how they dealt with the person's death and so forth, and they found no differences. They found that the people who went through the aid in dying process had no greater probability of having any kind of psychological problems as a result of that. The main differences they did find were that the people who went through that process said they were more prepared for the person's death and, in a sense, were more at peace and able to accept it.

THE COURT: So the family members of the persons who chose to utilize aid in dying were basically similarly situated to family members of the people who had terminal illness and the terminal illness went to its terminal conclusion?

THE WITNESS: That's correct.

THE COURT: I know here we've been talking about suicide, but I was interested in those other two groups, so you answered my question.

Q. (BY MS. SMITH) Now, competency is one of the requirements for physician aid in dying. And how does one determine competence, not just from the standpoint of mental illnesses that may be involved, but other types of competence?

THE COURT: Counsel, I'm sorry to interrupt, even though I keep doing it, but it sounds like we're sort of starting into a new area. It's seven minutes till noon --

MS. SMITH: This is almost the end.

THE COURT: Oh, it's almost the end?

MS. SMITH: Yes.

THE COURT: Then never mind.

MS. SMITH: But we can --

THE COURT: No, please continue.

MS. SMITH: Ten minutes?

THE COURT: Yes, Absolutely.

Are you okay, Janice?

COURT REPORTER: I'm fine.

THE COURT: Okay.

Q. (BY MS. SMITH) So in determining competency, how does one go about determining competence?

A. Okay. I'll try to do this part quick.

Q. Well, take your time.

A. Well, first of all, making sure the person doesn't have some kind of gross cognitive impairment or psychological impairment is part of what I was talking about earlier in terms of the psychological or psychiatric conditions they might have. But then in terms of the competence to agree to or to refuse a medical procedure or treatment usually involves establishing whether the person has certain understandings: Whether they understand the nature of the illness that they have so that they understand the nature of the treatment that is being proposed or the treatments that are being proposed and the alternative treatments that might be available, and whether they understand the consequences of either accepting the treatment or rejecting the treatment. So do they understand what would happen if they did or didn't take this surgery or this medication kind of treatment. And so once one establishes that, then they can pretty well feel that that person is capable of giving that kind of informed consent to that procedure. We call it "PAR," or "PARQ" is the acronym that most medical providers use.

Q. And what does that stand for?

A. Procedures, alternatives, and risks. I forget what the Q stands for.

Q. And is it common for physicians, not just psychiatrists, but for physicians to make these sorts of determinations in their practice?

A. Very common. In fact, most physicians are obligated to have that kind of conversation with their patient and to document that they had that kind of conversation when they are proposing certain kinds of treatment, and I failed to mention, that are part of the risks. They need to have a discussion with the patient about, "Do you understand what the potential harms are of this procedure?" so that they can be clear that the person who is doing this understands the potential side effects or risks that, say, they might have a risk of dying from being under anesthesia. It's a very common procedure.

Q. If a physician has any doubts about competence, what can they do?

A. They can request a consultation from someone else to help determine that, and in some cases they might say, "Well, I don't think" -- if they establish a person isn't competent, then they can decide whether to request some kind of substituted judgment, you know, conservator or guardian, depending on the circumstances.

Q. And when it comes to determining whether coercion of some sort might be in effect, are physicians able -- in their relationship with patients able to make determinations as well?

A. I think, generally, they should be able to. Sometimes it may be more subtle and they may want to get another person to look at the situation and confirm their intuition or their beliefs or their observations.

Q. Are there situations, other situations besides aid in dying, where this might be a factor that they need to establish?

A. Yeah. In relation to lots of medical interventions, it's an important issue to address throughout healthcare treatments.

Q. Are there situations that come up where another person's actions -- where a physician might determine that another person is acting to harm their patient?

A. I'm not sure I understand.

Q. Any kind of abuse?

A. Oh, sure. Sure. There's both the kind of subtle influencing them to make a decision, but there's also -- if there's overt evidence that someone is being abused, whether it's a child or an older person, in most states there are statutes that require a physician to report to the public authorities their suspicions of someone being a victim of some kind.

Q. And so physicians need to be on the lookout for more than just their individual patient, is that correct, in their analysis?

A. Yes; correct.

Q. And this is something that they're able to assess?

A. Yes. And we teach our medical students about this in a variety of contexts, including the ones that I think I mentioned but also including domestic violence.

Q. Now, do you believe that terminally ill -- well, let's talk a little bit about other types of medical interventions --

A. Okay.

Q. -- versus physician aid in dying. So in situations where a person -- are there certain situations where patients might seek to end a life-sustaining treatment?

A. Yes.

Q. And can you give me some examples of those situations?

A. I just mentioned a couple. The person who has cancer and is on chemotherapy and says, "I don't want anymore." The person who is on renal dialysis says, "I'm not going to do this any longer." The person who says, "No more feeding tube or extraordinary interventions for me in the event that I collapse."

Q. And do those people -- do you feel that a person who is mentally competent and terminally ill making that decision, is there any difference between that person and a person who chooses aid in dying?

A. Not really. It's the same circumstance. The main difference is they are electing to -- the person in the former situation is electing to stop something that is keeping him together, and the person in the position of requesting aid in dying is saying, "I want to stop at the point that I begin to deteriorate so I don't get to that point that I will have to be dependent on life support or that I will lose touch with my relationships and so forth." It's really the same kind of experience.

Q. What about somebody who is seeking palliative sedation due to their suffering and wants to alleviate that suffering, do you see a difference between a person seeking palliative sedation who will receive a dose of medication?

A. No. No, I don't think there's a great deal of difference in those. It kind of depends on how lucid the person is at the point. I mean, there may be some prior advanced directive or post-physician's orders or life-sustaining treatment document that they've completed that has established that, even though that person is now at a stage where they're not able to provide that kind of consent, they have established earlier that they would like this procedure to be done, the terminal sedation, for example, and it might be done under those circumstances.

Q. Whereas with physician aid in dying that determination would be made by who?

A. The determination of --

Q. To ingest medication.

A. It has to be determined by the patients themselves, so if something happens at a point where the person is still able to voluntarily and independently consume the medication that would end their life.

Q. And the last point I'd like to make is do you believe that there are any principles of medical ethics that support the practice of physician aid in dying?

A. Yes, I do. There are -- as I said, I'm a senior scholar in the Center for Ethics and Healthcare at OHSU, and I teach a lot related to ethics, so I've done a lot of deep thinking about this. There are four principles that people generally --

Q. Before you go on, have you read any studies about the principles of ethics as related to these type of end-of-life care decisions?

A. Yes, I have. There are four principles that people generally include in terms of medical ethics and thinking about what ways to decide what to do about someone. They involve beneficence, which is doing as much good as one can; nonmaleficence, which is don't do any further harm to the person; justice, which is involving is this a fair -- is what we're doing fair; and, finally, autonomy, or respect for the person.

And beneficence, in my view, includes -- especially in terms of how our health system and our health profession has shifted to more explicitly focus on patient-centered care, persons under care, there is much more of an emphasis on patient preference. And if all other things are equal, if beneficence, nonmaleficence, and justice issues are not so dominant, then most people agree that the autonomy or respect for the person trumps the other issues.

Beneficence needs to be looked at in terms of the overall quality of the person's life, not just, are we curing this particular organ from being as sick as it was for another four months? It's what the person believes is what he or she would determine is the quality of life which, more often than not, boils down to maintaining that sense of integrity of self.

There's another decision-making process that has been used that does take into account these principles, but it's a decision-making process that looks at what are the contexts that we're thinking about. One has to do with what are the medical considerations and situations that the person is going through; what are the facts? Another has to do with what are the person's preferences? What are the quality-of-life issues explicitly associated with their case? And, finally, what are the other context issues that have to do with the family, law, hospital policies, culture, other things that may come into play?

And so in a discussion, say, with an ethicist leading a team to decide what would be the best course of action, they would frame these things that way so they could have a rational and meaningful and comprehensive discussion of this. And I believe in many of the cases that we're talking about, when one goes through that process, they would see that cases like the ones who have been described today -- Ms. Riggs or like the one in the documentary or Dr. Morris described -- one would very likely go through that process and say, "This is actually the best choice," if this person is requesting it, that there are not ethical reasons to weigh against that.

Q. Thank you. So just -- very end -- I just want to give some more of your qualifications to make it clear to the Court, you stated that you had clinical practice experience for about twenty years or so; right?

A. Forty.

Q. Forty years. Okay. Sorry. Yes, forty. All right. So in that experience or in that time, how many evaluations -- how many times have you had to determine if somebody is mentally competent?

A. Oh, a number of times. Only once in relation to the aid in dying.

Q. But how many times generally?

A. Dozens. I have worked in court situations where there was a civil commitment process and done consultation when I have been on call at the hospital that included determining whether someone had the ability to make certain decisions for themselves. I was the medical director for Oregon Mental Health Division and so I had to deal with developing policies and processes for making those kinds of decisions, you know, dealing with things in our State Hospital system, as well as in the acute psychiatric hospitals.

I guess in preparing for this hearing I hadn't thought -- because I don't deal with this issue on a day-to-day basis, but I had dealt with it a lot when the law first passed in '94, and the second initiative position was in '96, and in the paper that we did, and then the various other policy processes that I have been involved with, the breadth of my experience in terms of being involved both at the policy level and by just circumstance being in Oregon when this law has been enacted and seeing what the impact of the law has been. Impact not just on people who have gone through this process, but also in increasing the dialogue in our medical community about improving end-of-life care, improving hospice care, improving pain management, leaving our Board of Medical Examiners to have more clear policies about undertreatment as well as overtreatment with pain medication. I think I'm probably one of the more knowledgeable persons in the country about this particular issue in terms of policy-related things, not in terms of just the clinical side.

Q. Have you reviewed a body of literature on this subject as well?

A. Yes, I have.

MS. SMITH: I have no further questions.

THE COURT: All right.

MS. SMITH: Oh, my esteemed co-counsel has said she thinks we should break for lunch and then ask more questions.

THE COURT: All right. So you're not resting at this point in time --

MS. SMITH: I'm not resting. I take it back.

THE COURT: -- but we are going to break for lunch.

All right. We will break for lunch. The Court will be in recess until 1:30. It's important that you-all know that we're expecting about 250 jurors at 1:45, so my suggestion, certainly for counsel, is that you are in line downstairs in time, obviously, to get back to the courtroom on time.

And for members of the public, I mean, you are not prohibited in any way from coming in and out while court is in session, as long as people are doing that quietly, of course, but I just wanted everybody to know about that.

So at this point we can go off the record.

(NOTE: Recess was taken from
12:10 p.m. until 1:35 p.m.)

THE COURT: All right. Continue please.

MS. SMITH: So, Your Honor, I wanted to make one thing clear. We discussed with co-counsel or opposing counsel -- we've got a lot of co-counsels, is part of the problem -- so we discussed with opposing counsel, that opposing counsel is stipulating to our experts as being experts for that purpose. I just wanted to let you know that.

THE COURT: Okay. So if I'm understanding you correctly, clearly, you are asking the Court to recognize Dr. Pollack as an expert?

MS. SMITH: Yes.

THE COURT: And he shall be so recognized. Are you asking to recognize Dr. Morris as an expert? She is a named party.

MS. SMITH: We're asking her as a plaintiff.

THE COURT: All right. So Dr. Pollack, Dr. Kress, and Dr. --

MS. SMITH: Gideonse.

THE COURT: -- Dr. Gideonse. All right.

MS. SMITH: And you said you accept Dr. Pollack as an expert?

THE COURT: Yes.

Q. (BY MS. SMITH) I have just a couple follow-up questions for you, Dr. Pollack. Just to clarify, is the impact on the loved ones of people who commit suicide different from the impact on loved ones of people who choose aid in dying?

A. Yes, it is. There's a significant difference. It relates in part to what I had described earlier about the difference between suicide and aid in dying, partly due to the fact that suicide is often an impulsive and solitary act. The loved ones are, more often than not, either unaware or not informed, or even if they have been concerned about their loved one being depressed or intermittently suicidal, when it happens, they're shocked and can go through a range of psychological reactions, most of them negative, that involve blame or shame or guilt or anger, surprise, but in a negative way. And those reactions, either turned inward towards the family member by themselves, or toward someone else, whether it's the person who committed suicide or some external factor; whether it's an individual or a group or something else that they can choose to put the responsibility on for this horrible thing having happened.

Whereas with aid in dying, the people who seemed to go through that, in the study that I was citing, showed that they really don't have much in the way of psychological consequences that are negative. The study that was done compared them with people who had relatives who died of similar conditions, just to see whether there was any difference based on the hypothetical premise that aid in dying would cause more psychological anguish and reactions in people, and they showed, indeed, it didn't. And, in fact, people who went through that practice with their loved one who had the terminal illness were, as I said before, more prepared for the death of their loved one and, in a sense, more at peace.

Q. In your expert opinion, is aid in dying suicide?

A. No, it is not.

Q. And in your opinion, is the physician's act of prescribing the medication assisting suicide?

A. No, it is not. And I'll cite the paper we wrote in 1998 where we spent all of two paragraphs saying: Here is why it's preferable to use something different than the concept of suicide or assisted suicide for this process because it's really aiding the death process. The person is already in the process of dying and it is simply facilitating or hastening that process.

MS. SMITH: Thank you.

MR. FUQUA: Your Honor, before we get started, just one thing I did want to make sure that we're all clear on. In light of the question counsel asked about this witness' expert opinion, what field?

MS. SMITH: We would like him to be recognized as a qualified expert as a psychiatrist as it pertains to end-of-life care and decision-making.

MR. FUQUA: That's about what I expected. I just wanted to make sure we were all on the same page.

THE COURT: All right.

///

CROSS-EXAMINATION BY MR. FUQUA

Q. Doctor, I want to talk with you, hopefully, in a targeted way about the opinions that you have just expressed about aid in dying not being suicide and about the act of writing a prescription for aid in dying not being assisting a suicide. Your opinion that aid in dying is not suicide, would it be fair to characterize that as a psychological opinion? And when I say that, I don't mean an opinion that evidences some principle of psychology, but an opinion in your capacity as an expert in the field of psychology.

A. First of all, I'm an expert in the field of psychiatry.

Q. I'm sorry.

A. And, secondly, I would say more it's a medical opinion. I see this in relation to the medical process of caring for patients irrespective of what kind of healthcare condition they have and what the process of chronic illnesses and terminal illnesses are.

Q. Okay. So it would be fair for me to characterize that opinion as a medical opinion?

A. That's correct.

Q. It's certainly not intended to be a legal opinion, is it?

A. I don't have the credentials to make a legal opinion, I don't think.

Q. I appreciate your candor. I would agree with you on that. The difference you elucidated this morning, I picked up anyway, is based on a number of factors -- and you will know these better than I do -- but one thing you mentioned is the patient's state of mind; correct?

A. Yes.

Q. The physical condition of the patient?

A. Yes.

Q. The consequences of the two different acts on those who survive the person who has died?

A. Those are factors to be considered.

Q. Is another one of those factors the collaboration -- I guess this is pretty closely related to the last one that we just talked about -- but collaboration between the person taking the act and that person's support of family members and friends?

A. Yes. Although I must say I don't think it is required by the law that a person has to have other people involved in their care other than their treating physician. They may not have family members involved.

Q. I don't mean to suggest that it does, Dr. Pollack.

A. Okay.

Q. I just wanted to make sure I understood the bases on which you were offering your medical opinion that aid in dying is not suicide.

A. Yes.

Q. Do you have any understanding of the pharmacological effect of taking the dosage of Seconal that is typically taken when prescribed in Oregon pursuant to the Death With Dignity Act?

A. I have a general understanding of it. Not being a pharmacologist or psychopharmacologist, even, I do understand the processes.

Q. What is your understanding?

A. Well, the barbiturates sedate central nervous system depressing qualities so that they will slow down the bodily functions of respiration, heart rate, and so forth. And in a high enough dose, they will lead to a person going into a comatose state.

Q. When you say that they will slow down those processes in a high-end dosage, is it fair to say that they will actually cause those processes to cease?

A. It will contribute to it. They may, because of coexistence of other pathological processes that the person is experiencing, whether it's not functioning as effectively in terms of respiration or their heart rate or something else, depending on the kind of illness that they have and the presence or absence of excess fluids and other complications of the illnesses or the other treatments that they're getting, the administration of those medications may collaborate or combine or in some synergistic way contribute to the death of that person or to the cessation of certain functions.

Q. Under the circumstances you have just described, where the underlying condition would -- I think -- I don't know if you said accelerate. I may just be making that word up.

A. I didn't say accelerate.

Q. Okay. Then I am just making that word up. But in the circumstances you just described, the underlying condition works in conjunction with the barbiturate to cease something like respiration, there isn't really any way to tell which of those two things resulted in the death of the patient, is there?

A. It would be very difficult, as far as I understand it, to discern which had how much proportionate impact.

Q. Now, when you say very difficult --

A. Impossible.

Q. -- it implies to me -- okay. So not just very difficult; it would be impossible?

A. Probably. And not worth the effort if it were possible, in my view, to -- whatever the method would be, it might be very expensive to figure out what that was.

Q. When you say "it's not worth the effort," that's because of what you consider the expense to be involved in making that determination?

A. It's also because it's kind of a moot point.

Q. But what if legally it wasn't a moot point, Doctor?

A. I don't know whether it's a legal moot point or not. I'm just saying in terms of the medical system, it would be less relevant than the person has now expired.

Q. I appreciate that but, respectfully, Doctor, that wasn't the question I asked.

A. Okay.

Q. If it did make a difference legally, is it still your opinion that it wouldn't be worth it to find out?

A. I don't know how to answer that. I don't know how you would value the level of worth in relation to a legal opinion.

Q. Sure. You described this morning earlier how people who seek aid in dying present differently than people who are suicidal or at least have expressed suicidal thoughts.

A. Yes.

Q. Do you remember that testimony?

A. Yes.

Q. When you say "they present differently," you don't mean that they show different psychiatric or psychological symptoms? At least I think that would be the wrong word because that sort of implies there would be a condition that the symptoms were symptomatic of. But do you mean that they exhibit different psychological or psychiatric profiles? Is that a fair way of putting it?

A. No, I don't think that's what I meant. I think -- if you're asking me to distinguish those who are suicidal from those who are requesting aid in dying --

Q. Yes.

A. -- and how they present, there's a qualifying issue here in terms of when this presentation is that you're talking about. I'm talking about once someone has started to consider requesting aid in dying and they've considered that that's something that they want to do, the way they present is in relation to, "This seems like a choice I either want to do or I want to consider doing," and that's very different than someone who is suicidal which, more often than not -- in fact, I can't imagine when it's not a product of a psychiatric illness; that the person who is suicidal has probably a major depressive disorder or some other psychiatric disorder or a complication of a psychological adaptation to some other illness and it is leading them to be overwhelmed by both their emotional feelings and their sense of hopelessness.

Q. So based on that, it sounds like it might actually be fair to characterize the way that a person with suicidal thoughts presents as "symptoms"?

A. Yes. A person who is suicidal -- suicidal thinking is one of the symptoms that they have.

Q. Right. I would like to talk to you a little bit about the nomenclature --

A. Sure.

Q. -- about the use of the label "assisted suicide," the use of the label "aid in dying," even something like "withdrawal treatment." Would it be possible for purposes of the medical community to differentiate between different kinds of suicides? Those that involve the kinds of things that you're talking about with people who present with suicidal ideation and suicides of the people who do not present with those symptoms but are, instead, the kind of people who are seeking aid in dying?

A. I wouldn't use the same terms that you're using. I don't think my use of the term "suicide" includes people who are not psychiatrically ill and who are already in the process of dying.

Q. I'm sorry. I think you just said your use of the term "suicide" includes those people?

A. I said it does not include.

Q. Does not. Okay. Thank you. That's what I would have expected you to say. I just wanted to make sure I heard you correctly. But the question I'm asking is maybe a little bit more abstract than that. I mean, you use particular nomenclature to express a psychiatric idea; correct?

A. Yes.

Q. I guess what I'm asking is, does it matter what the particular nomenclature you use is so long as the understanding in the medical and psychiatric community is what you have just expressed? Do you understand what I'm asking?

A. Well, I'm not entirely sure if we invented a new word that represented a concept and everyone said, "Yes, we can use that word for it and we will," okay. If you're saying can we apply -- you were saying a little while ago, can there be different types of suicide? There may be different types of suicide, but of the various types of suicide that I can conceive of, the person who's requesting aid in dying doesn't fit within that range of types of suicide.

Q. I think what I was really getting at is what you mentioned first, where you were just talking about having sort of created a phrase that the medical community has adopted.

A. Uh-huh.

Q. And do you think that's a fair way of characterizing what's happened with the phrase "aid in dying"?

A. I think it has become a more apt description of what has been a relatively more recent phenomenon in terms of the healthcare interventions or responses to these end-of-life conditions.

Q. I'd like to talk with you just a little bit about how recent those changes are. I think you testified earlier, from what I can glean from your CV, you were in Oregon in 1994 and 1996 --

A. That's correct.

Q. -- when these laws were passed; correct?

A. Yes.

Q. Now, in 1994 and in 1996, both, when that law was passed, isn't it true that the popular -- the popularly and the medically used terminology was "physician-assisted suicide"?

A. I believe that is true.

Q. And isn't it also fair to say that that phrase has been used, just within the last few years, in the literature on the subject?

A. It's been used with less frequency. And you may recall that I described a paper that a colleague of mine, David Smith, and I wrote that was published in 1998 in which we said, "Here are reasons why we think 'assisted suicide' is an inappropriate term for this process, and 'aid in dying' or 'physician aid in dying' is more apt." If you look simply at some of the papers that one of my colleagues, Linda Ganzini, from the same department of psychiatry that I'm in at the Oregon Health and Science University has written -- I was reviewing papers, obviously, for this case and I noticed that in a paper she wrote in, I think, 2001 she used the term "physician-assisted suicide" fairly frequently.

In a more recent article in 2009, there was virtually no reference to that term and more reference to "aid in dying." And I think she and other researchers in the field have been shifting their terminology, some more promptly than others.

Q. But just to be clear, that shift in terminology is using the different phrase to describe the same conduct; is that correct?

A. Yes.

Q. It might express a slightly different idea, but it's describing the same conduct; correct?

A. It's describing the same conduct and saying, This actually is a more apt and --

Q. Sure.

A. -- descriptive, more accurate description of what has previously been called "physician-assisted suicide."

Q. No, and I understand that. Are you familiar with the article -- when you said you had reviewed articles in preparation of this case, by any chance is one of those articles, *Differentiating Suicide From Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis*?

A. By Bostwick and Cohen?

Q. Yes, sir.

A. Yes.

Q. Published in, looks like, *Psychosomatics* in the January-February 2009 issue?

A. I read that paper.

MR. FUQUA: Your Honor, may I approach the witness?

THE COURT: Excuse me?

MR. FUQUA: May I approach the witness?

THE COURT: You may, yes.

MR. FUQUA: Counsel, this is the chart that I'm going to be talking about.

Q. (BY MR. FUQUA) I apologize, Doctor, in advance. I only have the one copy.

A. That's okay.

Q. It's my failure in preparation, but what it means is I may have to stand a little bit closer to you than you appreciate. Does this appear to you to be the article that we were just discussing?

A. It does.

Q. I just want to ask you a couple of quick questions. Now, actually, before I get too deep into the specific text, I want to point you to what the authors in this article did, which was construct a 2 by 2 matrix; all right? So you've got a four --

A. A four-quadrant grid.

Q. -- quadrant grid, and they put different kinds of end-of-life scenarios into those four quadrants.

A. Uh-huh.

Q. And one of them -- one of those quadrants they describe -- here, make sure I'm reading this correctly -- "Deaths that occur after withdrawing or withholding treatment when the achievement of an acceptable quality of ongoing life is considered futile." Did I read that correctly?

A. Uh-huh.

THE COURT: Yes or no?

THE WITNESS: Yes, I'm sorry.

Q. (BY MR. FUQUA) So following along here, "Also in the fourth quadrant" -- the quadrant we were just describing -- "is the small number of deaths that follow assisted dying." Do you see that?

A. Yes, I see that.

Q. And they further describe that as: The term assisted dying "includes both voluntary euthanasia (which is illegal in the United States) and 'physician-assisted suicide' (which is presently only in Oregon and now in Montana and Washington state, where voters recently endorsed it in the 2008 election) in which the physician gives the patient a prescription for a lethal amount of medication after he or she has gone through a protocol" --

THE COURT: You're speaking too fast.

MR. FUQUA: I'm actually surprised that's the first time this has happened. Maybe it's because I haven't said much so far.

Do you need me to back up?

COURT REPORTER: If you'd back up a sentence.

MR. FUQUA: I'm sorry.

Q. (BY MR. FUQUA) Starting with confirming, "confirming that he or she is making a free and competent decision to hasten death." Did I read all that correctly?

A. You did.

Q. And finally, "Neither method of assisted dying should be confused with withdrawal or withholding of life-support treatments." Did I read that part correctly?

A. Yes. Can I see the front of the article for a second?

Q. Yes, of course.

A. Just to refresh my memory about it.

Q. In fact, I'll let you hang onto that.

A. Okay.

Q. So I understand you were testifying earlier that your colleague had written a paper in 2001 --

A. Uh-huh.

Q. -- that uses the phrase "physician-assisted suicide" with some liberality, and in 2009 there was a similar article that didn't use the phrase, or at least didn't use it nearly as frequently?

A. That's correct.

Q. But here in 2009, this same year, we do see an article that describes the conduct of aid in dying as physician-assisted suicide; correct?

A. That is correct.

Q. We've kind of talked about this a little bit before, but I understand -- I understand, Doctor -- at least I think I do -- the reason that you've given for why aid in dying is a more apt term to describe the conduct of physician-assisted suicide and that, of course, centers on using the phrase, or word rather, "suicide"; correct?

A. That's in large part correct.

Q. But, again, when your colleague wrote that paper in 2001 and then the second paper in 2009, she used two different terms to describe the same conduct; namely, the provision of medication to a patient so that the patient can take that medication to end his or her life; is that true?

A. That's correct.

MR. FUQUA: I have nothing further. If I could retrieve my exhibit.

THE COURT: If that's an exhibit, then I think we should mark it and leave it.

MR. FUQUA: I say "exhibit." That will be entirely up to them, Your Honor. I do not intend to enter it into evidence.

THE COURT: Okay. Then retrieve your article.

MR. FUQUA: Thank you.

Thank you. I appreciate your time.

THE COURT: Redirect.

RECROSS-EXAMINATION BY MS. SMITH

Q. Briefly, regarding the evolution of the terminology, are you aware that medical organizations have rejected the term "physician-assisted suicide"?

A. I believe so, yes.

Q. And can you -- and that some of these include the American Public Health Association?

A. Public Health Association. I believe there may be national healthcare organizations that either involve social workers or psychologists or state organizations that have taken a similar position. I can't name the precise ones, but I know a number of professional health-related organizations have taken positions, both on the terminology, as well as their position in relation to supporting the concept.

Q. And so how -- what -- how have they taken a stand on supporting the concept?

A. I think, for example, the American Public Health Association position paper they've developed has endorsed this as an appropriate policy for states to adopt to allow the option for people to have the right to engage in or accept aid in dying in these circumscribed cases where they're imminently going to die from a terminal illness.

MS. SMITH: Thank you.

THE COURT: So just so I can be, I don't know, sort of -- perhaps try and get a succinct definition in my mind, this -- it sounds like what you're describing is a -- what's the word I want to use? -- a change over time and an accepted terminology within the medical community. That's what -- if I understand it, that's what you're testifying you believe has happened or is happening?

THE WITNESS: Yes. That is true. I believe that when concepts emerge in healthcare practice, they may be similar to something that people have seen before and they may make a miscalculation in terms of what they call it, and then over time the community of clinicians will accept something as being a more effective term or definition for that concept or process. But I don't think these researchers in this paper or other clinicians who are thinking about, "What shall we call it?" are thinking in terms of "What should the legal term be?" They're thinking more in terms of the clinical process and what we describe as that. But the fact that one or more researcher uses the term "assisted suicide" in a paper doesn't mean, ah-ha, therefore, it's physician-assisted suicide for legal purposes.

THE COURT: I think the researchers would probably not really want to bother with what the legal term of it is.

THE WITNESS: Absolutely.

THE COURT: So I was actually thinking over lunch and I was trying -- because I was thinking about this whole topic of the term, and I was trying to come up, in my mind, with other examples. And sort of the only thing I could come up with that -- and I don't think it's a good analogy -- but I'm thinking of what we used to call "mentally retarded," now we have the word "developmental disabled" and we have all gradations as opposed to this broad category of someone who we would term "mentally slow." But I was just wondering, I mean, you're a bioethicist.

THE WITNESS: Yes.

THE COURT: But is there anything else that comes to your mind when you think about that concept?

THE WITNESS: Sure.

THE COURT: What?

THE WITNESS: There are a lot of terms that have fallen out of favor for a variety of reasons whether there were pejorative associations with them. Like the term "senility" is not used as much now and we talk about people who have dementing illnesses, and not everyone who is old is senile necessarily. And the lack of precision is associated with certain terms, and what does it really mean? And here's where -- you know, suicide is a lack of precision in terms of what's being used here in terms -- in relation to that. Similar things in regard to gender identity, sexual orientation, there are terms that have been used in those areas that have been either flagrantly pejorative or have been confusing in their use. There are other areas, I imagine, as well, but those are examples.

THE COURT: Okay. And when we -- I think one of the first things you talked about was, I think, the DSM V. And the DSM V actually defines suicidal ideation as a --

THE WITNESS: Symptom.

THE COURT: Pardon?

THE WITNESS: As a symptom.

THE COURT: As a symptom. So it's not a diagnosis on its own; it's a symptom?

THE WITNESS: No, it's a symptom. It can be a symptom of a number of different conditions, a number of different diagnoses.

THE COURT: Okay.

THE WITNESS: You can have suicidal ideation as part of the symptom constellation --

THE COURT: Okay.

THE WITNESS: -- that makes it that diagnosis.

THE COURT: All right. Let me make sure I don't have any other questions. If you will just give me one second. And I just want to make sure -- I think I know the answer to this, but just for the record, you had talked -- when you were talking about -- let me find the word that you used. You talked about basically when somebody has what I would call a "durable healthcare power of attorney" for someone to make healthcare decisions. But that person who has that can't make this decision for them, can they?

THE WITNESS: No, I don't think so. There are circumstances where a person can construct what we either call an "advanced directive" --

THE COURT: Right.

THE WITNESS: -- or in the context of working with their physician there's a process that began in Oregon and spread to many other states called POLST, P-O-L-S-T, which stands for "Physician's Orders for Life-Sustaining Treatment," that the patient works out with the physician after a conversation about how they want to proceed with their end-of-life planning. And this is a specific form that they fill out and the physician signs, and it carries more weight than an advanced directive.

An advanced directive is simply a declaration that the patient makes about, "In the event I go to a hospital or I have this kind of circumstance, this is what I prefer to have happen." And what people have found is that in a lot of cases the hospital the person ends up at, they can't find the advanced directive, or if they get the advanced directive, they don't acknowledge it or honor it because of their concerns about medical/legal things.

THE COURT: Yeah.

THE WITNESS: So the POLST process has been one that has really gotten beyond that and it's really helped. Oregon actually has a central database they keep of the POLST forms for many people that our Center for Ethics in Healthcare helped to develop.

But back to your question about this. These are processes that might then include the appointment of someone as either a personal or medical representative or healthcare representative or having durable power of attorney, different terms used in different places for different functions, but that person would not have the ability to exercise the administration of medication for aid in dying. It's explicitly for the person who is the patient to administer, self-administer, take that medication. So they have to be in a place where they can still have the competence to both understand what they're doing and that the function of these medications will be to hasten their death and that they voluntarily and autonomously self-administer the medication.

THE COURT: Oregon, of course, has a statute that defines some of the parameters of this. I believe if I understood Dr. Morris' testimony correctly -- and you were here when she testified --

THE WITNESS: I came -- I was out in the antechamber for part of it, but I came in during the latter part, yes.

THE COURT: I believe she testified, if I'm not mischaracterizing her testimony, that she believes that there is a sufficient body of -- that's a bad word. I was going to say a sufficient body of medical protocol. I don't think that's what you-all would call it -- but there are sufficient protocols that have been developed over time that, because of the Oregon experience, I guess, that would define a physician's role in this without all the statutory parameters. Do you believe that?

THE WITNESS: Let me think about that. I think so, yeah. I think there's a common -- look, before we even had the issue in Oregon, there were kind of -- there was a process known as the "double effect." I don't know if it's been introduced here or not, but where physicians would, in a sense, treat the person with pain medication, because that was a symptom, knowing that there was a possibility that the side effect of that pain medication would oversedate them. And that was kind of a back-door way of people doing something that others felt should be more overt, and that if that's what we're doing, let's acknowledge it. And I think both before the Oregon law passed and since then, there has been more attention to: What is the physician's role? And that is part of why in Oregon, since 1994, we have had a dramatic improvement in end-of-life care by the provision of both hospice care in facilities, as well as visiting hospice workers and palliative care processes and better attention to the alleviation of the symptoms that are associated with terminal illness, such that our medical board will sanction physicians for undertreating pain as much as they would for people overtreating certain symptoms. And that's a new behavior for a medical board around the country.

I am guessing that other medical boards are adopting that set of standards as well, although I don't know. So, yes, I think the evolution of standards of practice and clarification of what is a physician's role has spread beyond the borders of Oregon and other states who either statutorily have this or are considering it.

THE COURT: In your opinion, are most standards for physicians statutorily imposed or medically imposed?

THE WITNESS: I think they are more medically imposed.

THE COURT: Thank you.

THE WITNESS: Thank you.

THE COURT: You may step down.

Call your next witness, please.

MS. IVES: Plaintiffs call Adrienne Dare.

(NOTE: Witness is sworn.)

THE COURT: Please be seated.

Counsel, just so you know, I need to take a break right

This is the annexure marked **"RGO4"** referred to in the affidavit
of **Richard Glynn Owens** affirmed at Auckland this day of
April 2015 before me

Signature .... 24/04/15 .... **"RGO4"**

A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

VIEWPOINT

The Changing Legal Climate for Physician Aid in Dying

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While once widely rejected as a health care option, physician aid in dying is receiving increased recognition as a response to the suffering of patients at the end of life. With aid in dying, a physician writes a prescription for life-ending medication for an eligible patient. Following the recommendation of the American Public Health Association, the term *aid in dying* rather than "assisted suicide" is used to describe the practice.[1] In this Viewpoint, we describe the changing legal climate for physician aid in dying occurring in several states (Table).

Voters in Oregon and Washington have legalized aid in dying by public referendum, legislators in Vermont have done so by statutory enactment, and courts in Montana and New Mexico have done so by judicial rulings. Support for aid in dying is increasing, and it would not be surprising to see voters, legislators, or courts in other states approve the practice. Indeed, in their 2014 sessions, at least 6 state legislatures considered proposals similar to the Vermont statute.

Although different states have authorized aid in dying through different legal routes, they all have extended the right to the same class of patients—mentally competent adults who are terminally ill. Even though patients can suffer greatly from disease before their final days, the 5 states have limited recognition of aid in dying to patients with an incurable condition that will likely result in death within 6 months[2] or within a "relatively short time."[3]

By restricting aid in dying to competent and terminally ill adults, the law can ease the dying process for patients, and their families, and avoid the potential for the mistreatment of patients.

This convergence on a right only for terminally ill persons to aid in dying is no coincidence. Indeed, it reflects a long-standing progression in end-of-life law. Society limits aid in dying to terminally ill patients to ensure that the practice is available only for individuals whose conditions might justify this option of last resort. The history of end-of-life law is instructive.

At one time, it was not clear whether patients could hasten death by refusing life-sustaining medical treatment. In the view of many people, turning off a ventilator, stopping dialysis, or discontinuing artificial feeding was an act of killing and should be unlawful. But beginning in 1976 with the *Quinlan* case in New Jersey[4] and an advance directive statute in California,[5] courts and legislatures concluded that patients may reject their physicians' treatment recommendations even when treatment is necessary to prolong life.

Recognition of the right to refuse life-sustaining care reflected a societal consensus that people should be able to decline treatment when they are suffering greatly from irreversible and severe illness. In such cases, the burdens of continued treatment may easily outweigh the benefits, and people should not be forced to endure a prolonged and undignified dying process.[6] What is critical about the right is the desire to protect seriously ill people from intolerable suffering.

How is it possible to decide when someone's illness is serious enough that treatment can be refused? The *Quinlan* case concluded that the right to refuse life-sustaining treatment should exist when the patient's prognosis becomes very grim.[4]

However, this approach raises serious problems. If judges must decide when a patient is so sick that the patient can refuse life-sustaining treatment, then the government ends up deciding who must live and who may die based on judgments about a person's quality of life. This approach would possibly lead to "death panels." Accordingly, later courts concluded that decisions whether to accept or refuse treatment "must ultimately belong to the one whose life is in issue."[7]

Although it is possible that someone will refuse life-sustaining treatment in the absence of a serious illness, that rarely happens. Moreover, when such refusals occur, they typically reflect important religious beliefs, as when a Jehovah's Witness refuses a blood transfusion. In short, it is possible to avoid having the government make quality-of-life decisions and still be confident that life-sustaining treatment will be refused by patients only in situations in which that option is warranted.

Although a right to refuse treatment did not go too far in allowing death-causing actions, many people felt it did not go far enough. For instance, some patients are seriously ill and suffering greatly from widely metastatic cancer or other advanced diseases, but are not dependent on life-sustaining treatment. For those patients, aid in dying can be an important option.

However, there are real risks if patients are allowed to receive a prescription for a lethal dose of medication. Not all patients who would ask for a prescription would be suffering from an irreversible and severe illness. Some might have become tired of life, depressed, or feel that that their life has insufficient meaning. Accordingly, a right to aid in dying could be recognized only

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Table. States Currently Legalizing Aid in Dying for Mentally Competent, Terminally Ill Adults

State	Year of Legalization	Path of Recognition	Eligibility Criteria	Citation for Statute or Court Decision
Oregon	1994 and 1997	Public referenda	Mentally competent, terminally ill adults	Or Rev Stat §§127.800-127.897
Washington	2008	Public referendum	Mentally competent, terminally ill adults	Rev Code Wash § 70.245
Montana	2009	State supreme court decision	Mentally competent, terminally ill adults	*Baxter v State of Montana*, 224 P3d 1211 (Mont 2009)
Vermont	2013	Legislation	Mentally competent, terminally ill adults	18 Vt Stat §§5281-5292
New Mexico	2014	State trial court decision (subject to reversal on appeal)	Mentally competent, terminally ill adults	*Morris v Brandenberg*, No. D-202-CV 2012-02909 (Bernalillo County, NM, January 13, 2014)

with assurances that access would be limited to patients who are truly seriously ill. In addition, as with the withdrawal of treatment, the government could not impose limits by making quality-of-life judgments.

The terminal illness requirement provides the right kind of limit for aid in dying. It does not empower the government to make quality-of-life judgments, and it restricts the practice to patients who are suffering from irreversible and severe disease.[8]

This is not just a matter of theory. Oregon has had more than 15 years of experience with aid in dying limited to the terminally ill, and the state's experience has been reassuring. Aid in dying is used rarely by dying patients—less than one-half of 1% of deaths result from the practice (less than 100 patients annually). Approximately 80% of aid-in-dying patients are terminally ill from cancer, and aid-in-dying patients are similar to other dying patients in terms of sex, race, health insurance coverage, and hospice enrollment. Moreover, aid-in-dying patients tend to have higher levels of education than other dying patients.[9] Vulnerable patients are not succumbing to aid in dying. It is not surprising that once Oregon's experience with aid in dying was reassuring, other states were willing to consider authorizing aid in dying.

Although many critics of aid in dying have been concerned that legal recognition of the practice would result in a slippery slope to abuse, those fears have not materialized in Oregon, Washington, or the other states that have given formal recognition to aid in dying. By restricting aid in dying to competent and terminally ill adults, the law can ease the dying process for patients, and their families,[10] and avoid the potential for the mistreatment of patients.

ARTICLE INFORMATION

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REFERENCES

1. American Public Health Association. Policy statement database. http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372. Accessed April 11, 2014.

2. Ore Rev Stat §127.800(12).

3. Mont Stat §50-9-102 (16).

4. *In re Quinlan*, 355 A2d 647 (NJ 1976).

5. Gelfand G. Living will statutes: the first decade. *Wisconsin Law Rev*. 1987(5):737-822.

6. Cantor NL. Quinlan, privacy, and the handling of incompetent dying patients. *Rutgers Law Rev*. 1977;30(2):243-266.

7. *Bouvia v Superior Court*, 179 Cal App 3d 1127, 1143 (1986).

8. Orentlicher D. The legalization of physician-assisted suicide. *N Engl J Med*. 1996;335(9):663-667.

9. Hall MA, Bobinski MA, Orentlicher D. *Health Care Law and Ethics*. New York, NY: Wolters Kluwer; 2013.

10. Ganzini L, Goy ER, Dobscha SK, Prigerson H. Mental health outcomes of family members of Oregonians who request physician aid in dying. *J Pain Symptom Manage*. 2009;38(6):807-815.

BRITISH JOURNAL OF PSYCHIATRY (2007), 190, 266–267. doi: 10.1192/bjp.bp.106.027136

SHORT REPORT

"RGO5"

Effect of barriers on the Clifton suspension bridge, England, on local patterns of suicide: implications for prevention

OLIVE BENNEWITH, MIKE NOWERS and DAVID GUNNELL

Summary We assessed the effect of the installation of barriers on the Clifton suspension bridge, Bristol, England, in 1998 on local suicides by jumping. Deaths from this bridge halved from 8.2 per year (1994–1998) to 4.0 per year (1999–2003; $P=0.008$). Although 90% of the suicides from the bridge were by males, there was no evidence of an increase in male suicide by jumping from other sites in the Bristol area after the erection of the barriers. This study provides evidence for the effectiveness of barriers on bridges in preventing site-specific suicides and suicides by jumping overall in the surrounding area.

Declaration of interest None.

A number of sites around the world, particularly bridges, have gained notoriety as places from which suicide by jumping is popular (Gunnell & Nowers, 1997). As many acts of self-harm are impulsive in nature (Mann, 2003), restricting access to commonly used methods can result in reductions in both method-specific and overall suicide rates.

While two studies have found barriers to be effective in the prevention of suicide by jumping from particular bridges (O'Carroll *et al*, 1994; Beautrais, 2001) neither study investigated thoroughly the effects on suicide by jumping from other sites nearby and overall suicides. In December 1998, two metre-high wire barriers were installed on the main span of the Clifton suspension bridge in Bristol. For architectural reasons similar protective measures were not placed on the buttress walls at either end of the bridge (a photograph of the bridge is available as a data supplement to the online version of this paper). We used local and national suicide data to assess the effectiveness of these barriers in suicide prevention.

METHOD

The Clifton suspension bridge is located at the centre of the geographic area served by the Bristol coroner (Nowers & Gunnell, 1996). The bridge is over 6 km from the nearest psychiatric hospital; it is 75 m above the river and the case fatality of jumps from the bridge is over 95%.

Coroners' inquest files were examined to obtain information on all suicides occurring in the Bristol area, 5 years before (1994–1998) and 5 years after (1999–2003) the installation of the barriers. All deaths with an inquest verdict of suicide were included in the study. Records of deaths given an open, accidental or misadventure verdict by the coroner were also examined, as previous research suggests that some deaths that are likely to be suicide are given such verdicts for legal reasons (O'Donnell & Farmer, 1995). For cases given these verdicts, vignettes describing the events leading up to the death were written (O.B.). The likelihood (high, medium, low or unclear) that these deaths were suicide was rated independently by D.G. and M.N., masked to the year of death. Only cases rated as medium or high likelihood were included in the study. Where the raters disagreed in their initial coding, consensus was reached through discussion. Of the 451 cases given a verdict other than suicide (open, $n=189$; accident or misadventure, $n=260$; no verdict, $n=2$), independent ratings by D.G. and M.N. resulted in agreement on inclusion or exclusion in 383 (84.9%) cases. After discussion a consensus on inclusion or exclusion was reached in the remaining 68 cases. We did not examine the coroner's files for accidental acute alcohol poisonings or deaths from illegal drug use or methadone poisoning, as determining the possibility of suicide in such deaths is particularly problematic.

For all cases of suicide information was obtained on the person's date of death, age and gender. To compute local and national rates of suicide, relevant population and mortality data were obtained from the Office for National Statistics on: (a) the number of suicides by jumping in England and Wales: ICD–10 codes X80 and Y30 (World Health Organization, 1992); (b) the overall number of suicides in England and Wales: ICD–10 codes X60–X84, Y10–Y34 excluding Y33.9 (where verdict pending); (c) population figures for the years 1994 to 2003.

Statistical analyses were carried out using Stata version 8.2 for Windows. Poisson regression was used to compare the number of deaths by jumping in the years before and after the construction of the barriers.

RESULTS

There were 987 suicides in the Bristol area over the 10-year study period. Of these deaths, 134 (13.6%) were suicides by jumping, 61 from the Clifton suspension bridge. There were a further 4 deaths where both the location of the body or skeletal remains and indications of trauma suggested that the person might have fallen from the bridge ($n=3$) or from nearby cliffs ($n=1$). All these deaths occurred before the barriers were erected, were given open verdicts and the remains were never identified; none of these deaths was included in subsequent analyses.

The number of deaths by jumping from the Clifton suspension bridge halved (from 41 to 20; $P=0.008$) in the 5 years after the construction of the barriers compared with the previous 5 years (Table 1). Ninety per cent (55 of 61) of the people who died in this way were male, and the decline in deaths was seen in men only.

Before the barriers were erected (1994–1998) 30 of the 31 suicides (97%) for which the site of the jump was recorded were from the span of the bridge and only one (3%) from the buttresses. In the subsequent 5 years nearly half (8/17) of the jumps for which the site was recorded were from the buttresses where no fencing was in place. In the 5 years after the construction of the barriers there was a non-significant increase compared with the previous 5 years in the number of deaths by jumping from sites other than the suspension bridge: from 6.2 deaths per year to 8.4 deaths per year ($P=0.2$). This increase was entirely due to a rise in female deaths by jumping – in keeping with national trends in female suicide by jumping (see Table 1).

This is the annexure marked **"RGO5"** referred to in the affidavit
of **Richard Glynn Owens** affirmed at Auckland this day of
April 2015 before me

Signature 24/04/15
A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

There was a non-significant fall in the mean number of deaths per year (14.4 to 12.4; $P=0.4$) by jumping from all sites in the area across the two study periods. This fall was due to a reduction in male ($P=0.017$) suicides by jumping. There was an increase in suicides by jumping among women ($P=0.001$). There was no change in the overall rate of suicide among those resident in the area during the periods before and after the placement of the barriers on the bridge: mean annual rate 11.2 per 100 000 *v.* 10.5 per 100 000, difference −0.7 (95% CI −1.9 to 0.9), $P=0.39$. This was the case for both men (difference −1.8 per 100 000, 95% CI −1.7 to 0.9) and women (difference 0.4 per 100 000, 95% CI −0.9 to 2.1).

DISCUSSION

The number of deaths by jumping from the Clifton suspension bridge halved following the installation of the preventive barriers. Although there was a decrease overall in the number of deaths by jumping in the area among men, this was not the case for women. However, any impact on female suicide rates would be expected to be minimal, as only one woman jumped from the bridge in the 5 years prior to the installation of the barriers and national data suggest that suicide by jumping among females is increasing, although the proportional increase across the two study periods was higher in the Bristol area.

This study provides evidence for the preventive role of barriers on bridges. There was some evidence that the presence of the barriers did not lead to an increase in deaths by jumping from other sites. The case-fatality rate among those jumping from the Clifton bridge is greater than 95%. Therefore, any displacement of people deterred from jumping to other methods of suicidal behaviour is likely to have a beneficial effect on levels of suicide, because no other method is associated with such a high case fatality. In view of continued suicides from some parts of the Clifton suspension bridge structure, further work to improve the safety of the site is warranted.

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Table 1 Suicides by jumping before (1994–98) and after (1999–2003) the installation of preventive barriers on the Clifton suspension bridge

Site of suicide by jumping	1994–1998	1999–2003	Difference in means (95% CI)[1]	*P*
Clifton suspension bridge				
All suicides				
Deaths/year, mean	8.2	4.0	−4.2 (−5.9 to −1.4)	0.008
Total deaths	41	20		
Male				
Deaths/year, mean	8.0	3.0	−5.0 (−2.6 to −6.3)	0.001
Total deaths	40	15		
Female				
Deaths/year, mean	0.2	1.0	0.8 (−0.08 to 8.4)	0.1
Total deaths	1	5		
Sites in Bristol other than the suspension bridge				
All suicides				
Deaths/year, mean	6.2	8.4	2.2 (−0.9 to 7.2)	0.2
Total deaths	31	42		
Male				
Deaths/year, mean	5.2	5.2	0 (2.2 to −3.8)	1.0
Total deaths	26	26		
Female				
Deaths/year, mean	1.0	3.2	2.2 (0.2 to 7.7)	0.023
Total deaths	5	16		
All sites in England and Wales (rates per 100 000)				
All suicides	0.34	0.36	0.02 (0.01 to 0.06)	0.2
Male	0.54	0.53	−0.01 (−0.07 to 0.06)	0.8
Female	0.15	0.20	0.05 (0.01 to 0.10)	0.005

1. Poisson regression analyses.

ACKNOWLEDGEMENTS

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REFERENCES

Beautrais, A. L. (2001) Effectiveness of barriers at suicide jumping sites: a case study. *Australian and New Zealand Journal of Psychiatry*, **35**, 557–562.

Gunnell, D. J. & Nowers, M. (1997) Suicide by jumping. *Acta Psychiatrica Scandinavica*, **96**, 1–6.

Mann, J. J. (2003) Neurobiology of suicidal behaviour. *Nature Review. Neuroscience*, **4**, 819–828.

Nowers, M. & Gunnell, D. J. (1996) Suicide from the Clifton Suspension Bridge in England. *Journal of Epidemiology and Community Health*, **50**, 30–32.

O'Carroll, P. W., Silverman, M. M. & Berman, A. L. (eds) (1994) Community suicide prevention: the effectiveness of bridge barriers. *Suicide and Life-Threatening Behaviour*, **24**, 89–99

O'Donnell, I. & Farmer, R. (1995) The limitations of official suicide statistics. *British Journal of Psychiatry*, **166**, 458–461.

World Health Organization (1992) *International Classification of Diseases and Related Health Problems* (ICD–10). WHO.

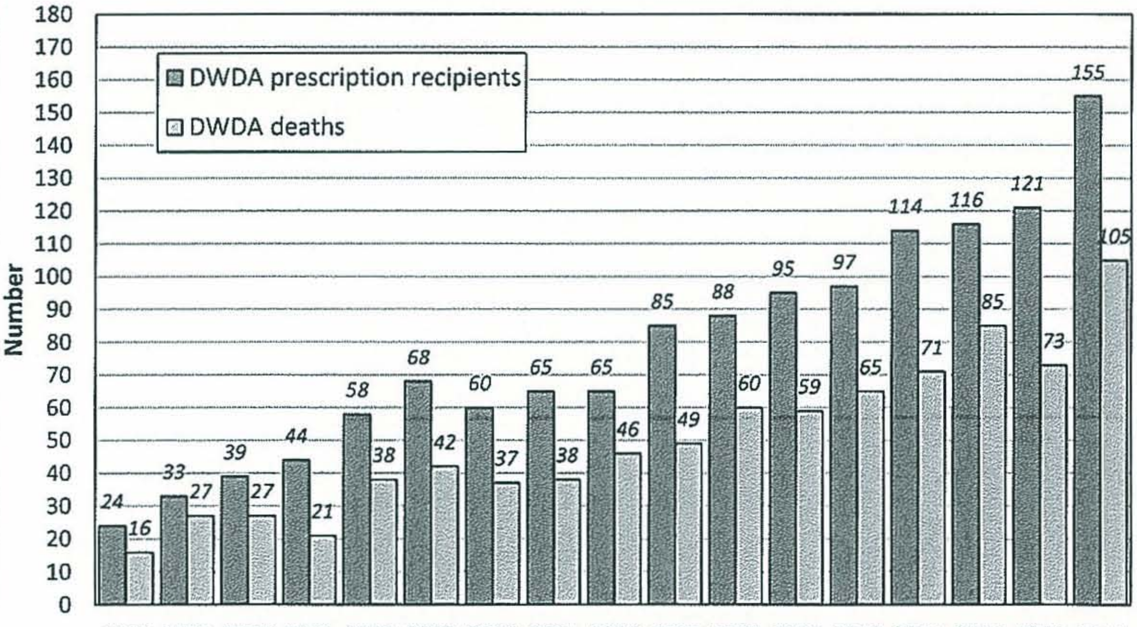
"RGO6"

Oregon Public Health Division

Oregon's Death with Dignity Act--2014

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014



*As of February 2, 2015

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.[1]

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[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

This is the annexure marked "**RGO6**" referred to in the affidavit of **Richard Glynn Owens** affirmed at Auckland this day of April 2015 before me

Signature .... 24/04/15 ....
A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

- Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the DWDA.
- Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication; all 94 patients died from ingesting the medication. No patients that ingested the medication regained consciousness.
- Eleven patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014.
- Thirty-seven of the 155 patients who received DWDA prescriptions during 2014 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 24 patients who were prescribed DWDA medications in 2014. For all of the 24 patients, both death and ingestion status are pending (Figure 2).
- Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had a least a baccalaureate degree).
- While most patients had cancer, the percent of patients with cancer in 2014 (68.6%) was lower than in previous years (79.4%), and the percent with amyotrophic lateral sclerosis (ALS) was higher (16.2% in 2014, compared to 7.2% in previous years).
- While similar to previous years that most patients had cancer (68.6%), this percent was lower than the average for previous years (79.4%); in contrast, the percent of patients with ALS was higher in 2014 (16.2%) than in previous years (7.2%).
- Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (39.8%) was lower in 2014 than in previous years (62.9%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60.2% compared to 35.5%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).
- Three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%) during 2014 compared to 15.9% in previous years.

- A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 20 of the 105 DWDA deaths during 2014. Among those 20 patients, time from ingestion until death ranged from eleven minutes to one hour.
- Eighty-three physicians wrote 155 prescriptions during 2014 (1-12 prescriptions per physician).
- During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2014, as of February 2, 2015

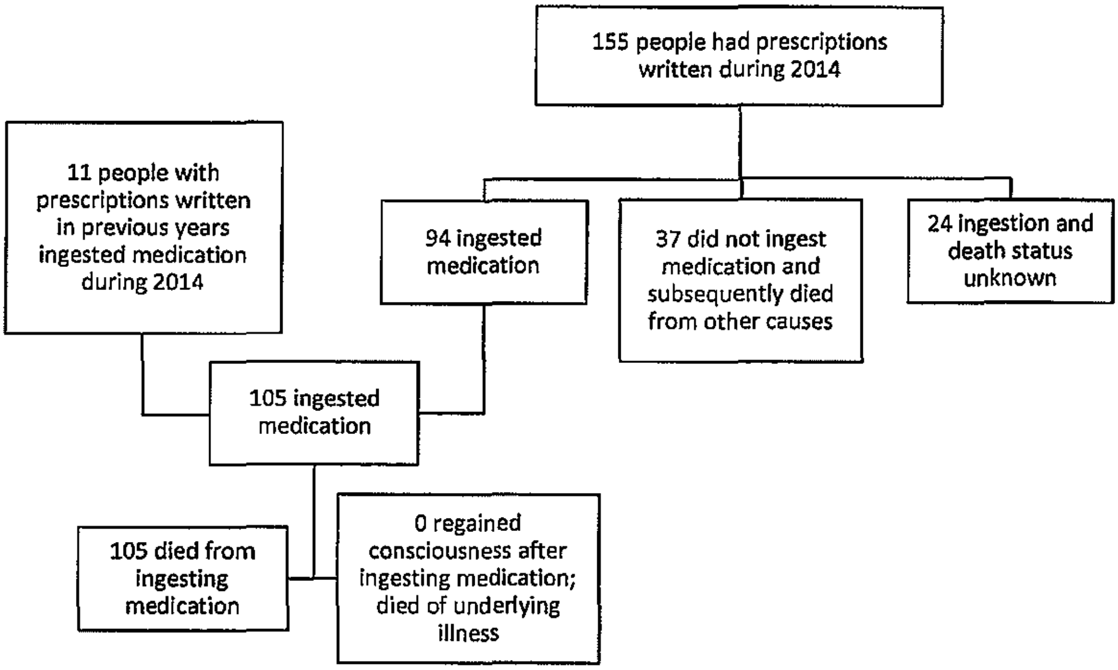

Table 1. Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Sex	N (%)[1]	N (%)[1]	N (%)[1]
Male (%)	56 (53.3)	397 (52.7)	453 (52.7)
Female (%)	49 (46.7)	357 (47.3)	406 (47.3)
Age at death (years)			
18-34 (%)	1 (1.0)	6 (0.8)	7 (0.8)
35-44 (%)	2 (1.9)	16 (2.1)	18 (2.1)
45-54 (%)	3 (2.9)	58 (7.7)	61 (7.1)
55-64 (%)	28 (26.7)	156 (20.7)	184 (21.4)
65-74 (%)	29 (27.6)	218 (28.9)	247 (28.8)
75-84 (%)	23 (21.9)	206 (27.3)	229 (26.7)
85+ (%)	19 (18.1)	94 (12.5)	113 (13.2)
Median years (range)	72 (29-96)	71 (25-96)	71 (25-96)
Race			
White (%)	100 (95.2)	731 (97.3)	831 (97.1)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.3)	2 (0.2)
Asian (%)	1 (1.0)	8 (1.1)	9 (1.1)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	2 (1.9)	1 (0.1)	3 (0.4)
Two or more races (%)	1 (1.0)	2 (0.3)	3 (0.4)
Hispanic (%)	1 (1.0)	5 (0.7)	6 (0.7)
Unknown	*0*	*3*	*3*
Marital Status			
Married (%)[2]	48 (45.7)	347 (46.2)	395 (46.1)
Widowed (%)	26 (24.8)	172 (22.9)	198 (23.1)
Never married (%)	6 (5.7)	63 (8.4)	69 (8.1)
Divorced (%)	25 (23.8)	169 (22.5)	194 (22.7)
Unknown	*0*	*3*	*3*
Education			
Less than high school (%)	6 (5.7)	45 (6.0)	51 (6.0)
High school graduate (%)	23 (21.9)	164 (21.9)	187 (21.9)
Some college (%)	26 (24.8)	198 (26.4)	224 (26.2)
Baccalaureate or higher (%)	50 (47.6)	342 (45.7)	392 (45.9)
Unknown	*0*	*5*	*5*
Residence			
Metro counties (%)[3]	46 (44.7)	315 (41.9)	361 (42.3)
Coastal counties (%)	6 (5.8)	57 (7.6)	63 (7.4)
Other western counties (%)	40 (38.8)	325 (43.3)	365 (42.7)
East of the Cascades (%)	11 (10.7)	54 (7.2)	65 (7.6)
Unknown	*2*	*3*	*5*
End of life care			
Hospice			
Enrolled (%)[4]	93 (93.0)	654 (90.0)	747 (90.3)
Not enrolled (%)	7 (7.0)	73 (10.0)	80 (9.7)
Unknown	*5*	*27*	*32*
Insurance			
Private (%)[5]	37 (39.8)	452 (62.9)	489 (60.2)
Medicare, Medicaid or Other Governmental (%)	56 (60.2)	255 (35.5)	311 (38.3)
None (%)	0 (0.0)	12 (1.7)	12 (1.5)
Unknown	*12*	*35*	*47*

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Underlying illness			
Malignant neoplasms (%)	72 (68.6)	596 (79.4)	668 (78.0)
Lung and bronchus (%)	16 (15.2)	139 (18.5)	155 (18.1)
Breast (%)	7 (6.7)	57 (7.6)	64 (7.5)
Colon (%)	5 (4.8)	49 (6.5)	54 (6.3)
Pancreas (%)	9 (8.6)	47 (6.3)	56 (6.5)
Prostate (%)	2 (1.9)	33 (4.4)	35 (4.1)
Ovary (%)	5 (4.8)	28 (3.7)	33 (3.9)
Other (%)	28 (26.7)	243 (32.4)	271 (31.7)
Amyotrophic lateral sclerosis (%)	17 (16.2)	54 (7.2)	71 (8.3)
Chronic lower respiratory disease (%)	4 (3.8)	34 (4.5)	38 (4.4)
Heart Disease (%)	3 (2.9)	14 (1.9)	17 (2.0)
HIV/AIDS (%)	0 (0.0)	9 (1.2)	9 (1.1)
Other illnesses (%)[6]	9 (8.6)	44 (5.9)	53 (6.2)
Unknown	*0*	*3*	*3*
DWDA process			
Referred for psychiatric evaluation (%)	3 (2.9)	44 (5.9)	47 (5.5)
Patient informed family of decision (%)[7]	95 (90.5)	634 (93.6)	729 (93.2)
Patient died at			
Home (patient, family or friend) (%)	94 (89.5)	716 (95.3)	810 (94.6)
Long term care, assisted living or foster care facility (%)	8 (7.6)	29 (3.9)	37 (4.3)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	3 (2.9)	5 (0.7)	8 (0.9)
Unknown	*0*	*3*	*3*
Lethal medication			
Secobarbital (%)	63 (60.0)	403 (53.4)	466 (54.2)
Pentobarbital (%)	41 (39.0)	344 (45.6)	385 (44.8)
Other (%)[8]	1 (1.0)	7 (0.9)	8 (0.9)
End of life concerns[9]	(N=105)	(N=754)	(N=859)
Losing autonomy (%)	96 (91.4)	686 (91.5)	782 (91.5)
Less able to engage in activities making life enjoyable (%)	91 (86.7)	667 (88.9)	758 (88.7)
Loss of dignity (%)[10]	75 (71.4)	504 (80.6)	579 (79.3)
Losing control of bodily functions (%)	52 (49.5)	376 (50.1)	428 (50.1)
Burden on family, friends/caregivers (%)	42 (40.0)	300 (40.0)	342 (40.0)
Inadequate pain control or concern about it (%)	33 (31.4)	178 (23.7)	211 (24.7)
Financial implications of treatment (%)	5 (4.8)	22 (2.9)	27 (3.2)
Health-care provider present[11]	(N=105)	(N=684)	(N=789)
When medication was ingested[12]			
Prescribing physician	14	119	133
Other provider, prescribing physician not present	6	238	244
No provider	4	76	80
Unknown	*81*	*251*	*332*
At time of death			
Prescribing physician (%)	14 (13.9)	107 (15.9)	121 (15.7)
Other provider, prescribing physician not present (%)	6 (5.9)	263 (39.2)	269 (34.8)
No provider (%)	81 (80.2)	301 (44.9)	382 (49.5)
Unknown	*4*	*13*	*17*
Complications[12]	(N=105)	(N=754)	(N=859)
Regurgitated	0	22	22
Seizures	0	0	0
Other	0	1	1
None	20	487	507
Unknown	*85*	*244*	*329*
Other outcomes			
Regained consciousness after ingesting DWDA medications[13]	0	6	6

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship[14]			
Median	19	12	13
Range	1-1312	0-1905	0-1905
Number of patients with information available	*105*	*752*	*857*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	43	48	47
Range	15-439	15-1009	15-1009
Number of patients with information available	*105*	*754*	*859*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness[11, 12]			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	*20*	*487*	*507*
Number of patients with information unknown	*85*	*267*	*352*
Minutes between ingestion and death[11, 12]			
Median	27	25	25
Range (minutes - hours)	11mins-1hr	1min-104hrs	1min-104hrs
Number of patients with information available	*20*	*492*	*512*
Number of patients with information unknown	*85*	*262*	*347*

[1] Unknowns are excluded when calculating percentages.

[2] Includes Oregon Registered Domestic Partnerships.

[3] Clackamas, Multnomah, and Washington counties.

[4] Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

[5] Private insurance category includes those with private insurance alone or in combination with other insurance.

[6] Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

[7] First recorded beginning in 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

[8] Other includes combinations of secobarbital, pentobarbital, phenobarbital, and/or morphine.

[9] Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

[10] First asked in 2003. Data available for all 105 patients in 2014, 625 patients between 1998-2013, and 730 patients for all years.

[11] The data shown are for 2001-2014 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

[12] A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

[13] There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

[14] Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

"RGO7"

On the 30th day of JUNE, 2014, the Official Court Reporter for the Second Judicial District filed in the Office of the Clerk of the Court a Transcript of Proceedings on Appeal to the NEW MEXICO COURT OF APPEALS.

SECOND JUDICIAL DISTRICT COURT
COUNTY OF BERNALILLO
STATE OF NEW MEXICO

Case No. D-202-CV-2012-02909

COA No. 33,630

This is the annexure marked **"RGO7"** referred to in the affidavit of **Richard Glynn Owens** affirmed at Auckland this day of April 2015 before me

Signature 24/04/15
A Solicitor of The High Court of New Zealand
(Solicitor to sign in part on Exhibit) Samuel Robert Gapes

KATHERINE MORRIS, M.D.,
AROOP MANGALIK, M.D., and
AJA RIGGS,

Plaintiffs,

vs. VOLUME 2 OF 3

KARI BRANDENBURG, in her official capacity as District Attorney for Bernalillo County, New Mexico, and GARY KING, in his official capacity as Attorney General of the State of New Mexico,

Defendants.

TRANSCRIPT OF PROCEEDINGS

On the 11th day of December, 2013, at approximately 11:04 a.m., this matter came on for hearing in a BENCH TRIAL before the HONORABLE NAN G. NASH, DIVISION XVII, Judge of the Second Judicial District Court, State of New Mexico.

(NOTE: Recess was taken from
10:15 until 10:32 a.m.)

THE COURT: Please be seated.
All right. Call your next witness, please.

MS. SMITH: Your Honor, plaintiffs call Aja Riggs.

THE COURT: Okay.

(NOTE: Witness is sworn.)

THE COURT: Please be seated.

AJA RIGGS

(being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. SMITH

Q. Please state your full name for the Court.

A. Aja Riggs.

Q. And where do you live?

A. Santa Fe.

Q. How long have you lived there?

A. Since the fall of 2009.

Q. And where are you from?

A. Originally, from Rode Island.

Q. How old are you?

A. I'm 49.

Q. What is your profession?

A. I'm a self-employed professional organizer.

Q. How long have you been in that work?

A. Since 2004.

Q. What sort of work did you do before that?

A. I did a number of different things. Most of my work involved working with people with different kinds of disabilities.

Q. Where did you go to college?

A. In Massachusetts, at Hampshire College, and then I graduated from UMASS, also in Massachusetts.

Q. And in what subject did you receive your Bachelor's Degree?

A. It was a self-designed major, transpersonal counseling and psychology.

Q. Ms. Riggs, have you ever been diagnosed with a life-threatening illness?

A. Yes.

Q. And what was it?

A. It's uterine cancer.

Q. When were you diagnosed?

A. In late August, 2011.

Q. And what were you told when you were initially diagnosed?

A. I was told that a biopsy revealed cancer and that it was the least aggressive kind and that it would probably be Stage 1 and that I would just need to have a hysterectomy and that I would be cured.

Q. And so what did you do after that?

A. Then I had surgery in October, and the cancer at that point was discovered to have spread much further and to be the most aggressive kind.

Q. So after this discovery, what sort of treatments did you go through after that?

A. I had, altogether, two different kinds of chemotherapy and two different kinds of radiation.

Q. And can you explain, what did you do first, right after your surgery?

A. After a month of some amount of recuperation, we started chemotherapy with two different chemotherapy drugs.

Q. And how many courses of chemotherapy did you do?

A. Three at that time.

Q. And did your chemotherapy go smoothly?

A. No.

Q. Can you explain what happened?

A. I had an unusual reaction to one of the chemotherapy drugs that, I believe, was an anaphylactic reaction. They were able to control that, and we tried again the next day with a lot more steroids to allow me to be able to tolerate it.

Q. So when you say "an anaphylactic reaction," what was the physical reaction that your body had?

A. I was told that I turned bright red and my chest had this incredible sensation of tightness. I honestly don't remember if there were other things. That kind of blocked out everything else.

Q. And so what happened after you had those troubles with chemo; were there any other problems you experienced?

A. Yes. I also had vein-related trouble. I was getting the chemo in an IV at that time. That caused some painful reactions, one of which I was advised to go to the emergency room to check out to make sure that it wasn't something that could cause more harm. The worst thing that happened was when I became neutropenic, meaning that my white blood cells were very low, which is -- it's normal for the white blood cells to reduce, to decrease during the cycle of chemotherapy, but I was told I had zero neutrocells, which is a kind of white blood cell, and I developed a tube-related infection. I did get to the emergency room in time and was admitted to the hospital, where I was given IV antibiotics.

Q. Now, when you were there, was this kind of infection something that was -- something that caused the staff there -- how was their reaction to this infection?

A. In the emergency room, I noticed they were not joking with me much and looking rather nervous, and it was only later that I understood the full extent of the seriousness of my situation.

Q. And what was the full extent of the seriousness?

A. I could have died.

Q. Now, so you had these problems with chemotherapy, but how did you feel having chemotherapy? What were the effects on how you felt?

A. I felt extreme fatigue. There were times when just getting out of bed and walking 15 feet just felt like uphill, everything being incredibly uphill, and times that I -- it was too much effort to even talk. I was very fortunate that I had friends who came -- I always had somebody with me during those times to keep -- to make food and just kind of keep things rolling along for me. I couldn't have -- I can't imagine not having that support.

Q. After your -- how many weeks did these courses of chemo -- how long for your first three courses of chemotherapy; how long did that last?

A. About three months.

Q. After you had -- went through this chemotherapy, what happened after that?

A. Right after the last infusion, I had had a biopsy on a lump that had developed and grown through the chemotherapy and that was discovered to be cancer also.

Q. And is there a name for that sort of cancer?

A. It was the same cancer. At the time, my doctor then called it "chemo-resistant" and, I believe, "persistent."

Q. So what was the prognosis, once you were given that diagnosis?

A. It didn't look good. It looked like there was a high likelihood that the cancer could have spread other places in my body. It was -- sorry. Even thinking about it is a little difficult.

Q. I understand. Take your time.

A. It looked that it could cause my death pretty soon.

Q. So given this diagnosis, did you engage in any other kind of treatment at that point?

A. Yes. Right away, with great haste, we went into doing radiation therapy.

Q. And what does that entail?

A. I had two different kinds: One, external, whole-pelvic radiation. And that was -- the actual treatment was once a day for five days a week for five weeks. And that was followed by three weeks of internal radiation, once a week for three weeks.

Q. And what were the side effects to you from this treatment; how did it make you feel?

A. There was quite a number. Like the side effects with chemo, the elements are too many to remember. I'm probably not wanting to remember all of them, but with radiation, the skin burning, basically. A lot of pain that way. I was nauseous pretty much the whole time. It was difficult to eat. I found about, I don't know, four or five things that I could eat. More fatigue. I think -- I'm thinking about the different prescriptions that I took for each thing. It seemed like I was shifting from one set of side effects and a way to manage that to another one for radiation, and then, once I figured out how to deal with all that, I was back in chemo and had a whole 'nuther set.

Q. So after that radiation, then you progressed to another round of chemotherapy?

A. Uh-huh. Two different drugs were used then because I guess we figured that the first two hadn't really worked.

Q. Now, at what point during this process did you become a plaintiff in this lawsuit?

A. It was somewhere during radiation treatment when I heard about the case being filed, and --

Q. How did you hear about it?

A. I heard about it on the radio. And I immediately looked on the web for the name of the organization that was mentioned and wrote an e-mail saying how important this issue was to me and that I would like to help out in some way.

Q. And through that, is that how you ultimately came to be a plaintiff?

A. Yeah. I received -- surprisingly, received a phone call asking me if I would consider joining the suit. And I had to think about it for a while, or at least I had to pretend to think about it for a while. Actually, the answer was one of those things that just comes up when you know you are going to do something because it's the right thing to do, so I said yes.

Q. Had you had -- before you became a plaintiff in this lawsuit, had you considered what the end of your life would be like?

A. When that additional tumor was discovered and it looked like the disease might be progressing pretty quickly, it was at that point that I began to think very seriously about what a death from cancer might be like. I had thought when I got the first -- what I call "the first" diagnosis, originally cancer, that's a life-threatening illness, but my chances were so good for survival at that point, I didn't really think a whole lot about dying from it. And even during the first part of treatment, when I knew my chances were much less, were much more reduced from that, I didn't actually think about dying a whole lot. But when I got to that point, I started thinking what it would really be like to die from cancer, and I remember thinking, I just don't know if I want to go all the way to the end of a death from cancer.

Q. What were some of the things you feared about the end?

A. I think one of the images that I had that I didn't and I don't want to have happen is that I'm lying in bed in pain, or struggling not to be in pain, or mostly unconscious with everybody that cares about me around me and all of us just waiting for me to die.

Q. Did you ever consider ending your own suffering, should it get to that point?

A. When I first started thinking about it, I'm not sure if I want to go all the way to the end with a death from cancer, I thought, Okay, in New Mexico, if I want to choose a more peaceful death and if I want to end my suffering, it may be seen as a crime. And so I didn't want to talk about it with anybody that was close to me. I didn't want to talk about it with my family or my friends, my closest support people. I didn't want to talk about it with my doctor. I didn't want to implicate anybody else in what might be a crime.

And so I thought, I need to prepare to do this all by myself, and that would mean that I would need to die alone and in isolation. That's as far as my thinking went at that point until I heard about the lawsuit, and then I thought, Of course, nobody should die that way. I don't want to die that way, alone and afraid. I want to have my friends there and my family there, and my physician, who I have been through a lot with, involved in that. Of course.

Q. After you became a plaintiff in this lawsuit, you went through your second round of chemotherapy. What happened with your diagnosis?

A. Fortunately and surprisingly, I had a scan about a year after my initial diagnosis that didn't -- that showed no evidence of disease. And as far as we know, that has lasted.

I don't really know for sure, but it seems to be that the cancer is still in remission.

Q. So your cancer is in remission; is that correct?

A. As far as we know, yeah.

Q. And do you have any -- do your doctors or do you have any sense of how long this will last?

A. No. The last time I saw my doctor, she said it lasted longer than expected already, so I'm feeling pretty lucky.

Q. Since you have been in remission, what have you been doing with your life?

A. I have been feeling like I've been given such a gift, that every day is, what we call in my cancer support group, "bonus time." I'm in bonus time and it's a gift. And to make the most of it, I've been doing some traveling. I got myself an old camper van and I'm traveling around the country to see some of the most beautiful natural places and spend time with the people that I really care about the most.

Q. How do you feel about your -- you've been through quite an experience. How do you feel -- what has been the support that you've had through this? Who has been your support?

A. I have had such tremendous love and support around me through every step of it. Every single step. I often talk about "we" reached remission, because I feel so grateful to have such an amazing support system around me.

Q. When you say "we," who are you talking about?

A. Friends, my family, the excellent medical people that I have been able to have involved in my care. It's just been tremendous.

Q. And with your medical people that you refer to, have you developed a close relationship with some of these providers?

A. Yes.

Q. And do you feel like they have gotten to know you well?

A. Uh-huh, yes.

Q. Have you discussed why, if you -- why is this an option that is important to you? Why would you want to have the option of aid in dying if your cancer returned?

A. There's a couple different reasons. Having it available as an option brings me a lot of peace of mind. It helps me to feel that I have a continuing ability to make choices about my experience with the cancer and my -- what's available to help with the pain and suffering that I might experience. I think that sense of choice and involvement has been really important to me all along, and it's something that brings me a great deal of comfort at this point even, the idea of being able to have that option available.

I don't want to suffer needlessly at the end. I have no idea what the end of my life might be like. I have no idea where the cancer might show up next in my body, what kind of pain it might cause, what kind of symptoms, what might be available to help treat those things. Those are all unknowns, but I do know that I want to have the ability to end my suffering if it becomes unbearable to me.

Q. If you were diagnosed as terminally ill and given a prescription for the medication used in aid in dying, would you automatically take this medication?

A. No. No. I would have to see. Like I said, what I was experiencing, if I'm able to have a death that seems like a good quality death to me, a dying process without using the prescription, I would do that. If it looked like that was only going to be possible with using the prescription, I would want to do that.

Q. If your cancer returned, would you try other courses of treatment, things you've already tried, possibly surgery or chemotherapy or things like that?

A. I would certainly have very detailed conversations with my oncologist about what were options, what might be gained by using some of those things, and what -- and how much any of those treatments might compromise the quality of my life, other things that might be important to me at that time also. It seems to me a one-step-at-a-time kind of decision-making process.

Q. Do you want to die?

A. No. I don't want to die. I don't want to die of cancer.

Q. Have you talked to your family about aid in dying?

A. I have, yeah. I talked very explicitly with them about it as I was deciding to be a part of the lawsuit, and they were very supportive.

Q. Do you consider it important to have a natural death, quote, unquote, natural death?

A. Because doing things a natural way is very important to me, it's a question that I've thought about, and I think it's difficult to answer in a black-and-white kind of way. When I was first -- when I first started having symptoms but before any idea of cancer entered into the scene at all, the first way that I addressed it was with a naturopath. It's the way I like to address most things. It's the way that makes the most sense to me.

So the question of what's natural is one that I have thought about a lot, and I actually wouldn't be here today if I only did things that were natural. I often wonder how natural is surgery? How natural is chemotherapy? Radiation treatment? And yet my desire to live, to continue having a good life is very natural, and so that led me to want to have those treatments. If I'm dying, in the dying process, I think there's nothing more natural than wanting a peaceful death. And so how do I create that?

Q. What would you consider to be a good death?

A. For me, having the presence of the people that I care about the most, who care about me the most; being at home, not being in the hospital; not having a lot of medical interventions that interfere with my ability to communicate or function as I would like to; to not have pain to the extent that it compromises my ability to connect with people or to be present in the moment; a sense of gentleness and peace to it.

MS. SMITH: Thank you.

MR. FUQUA: I have no questions for Ms. Riggs.

THE COURT: So you indicated that you were worried about having conversations with anyone that might implicate them into doing something that could be considered a crime. So when you got this diagnosis of the chemo-resistant tumor that had grown despite chemotherapy, did you have any discussions with your physicians regarding end of life at all? Was anything laid out to you?

THE WITNESS: No. No. I knew that I wanted to talk about it, but some of what I wanted to be able to talk about was an option like physician aid in dying and I was nervous about talking about that. And I also knew when that tumor developed and it was looking like the disease was progressing or may be progressing fairly quickly, I knew that I wasn't given six months to live. I have never been told that I was terminally ill, so it always seemed to me that there was plenty of time to have that conversation. At that moment in my treatment, we were all about, let's try to address this, get through the treatment. There's still some hope. Let's focus on that.

THE COURT: Assuming that your cancer returns and if you had the ability to make the choice, what would you consider that you were doing?

THE WITNESS: If I had the ability --

THE COURT: The ability to get a prescription, what would you consider that you were doing?

THE WITNESS: If I used the prescription?

THE COURT: Yes.

THE WITNESS: I would consider it to be ending my suffering.

THE COURT: During your treatment, were you prescribed other drugs to assist with your suffering?

THE WITNESS: There were so many -- sorry. There are so many prescriptions. I'm trying to think if I was prescribed pain relief in particular. Well, certainly with the surgery and then with chemo, several different medications that would help with some of the effects of chemo that were difficult.

THE COURT: Those are all my questions. Thank you for your testimony. You may step down.

Call your next witness, please.

MS. SMITH: Your Honor, I would call Dr. David