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 COLIN JAMES GAVAGHAN
AFFIRMED 15th MAY 2015

RUSSELL McVEAGH

A S Butler | C J Curran | C M Marks
Phone +64 4 499 9555
Fax +64 4 499 9556
PO Box 10-214
DX SX11189
Wellington

I, **COLIN JAMES GAVAGHAN**, of Dunedin, academic, solemnly and sincerely affirm:

1. I am the inaugural Director of the New Zealand Law Foundation Centre for Law and Policy in Emerging Technologies and an associate professor in the Faculty of Law at the University of Otago.

2. I consider myself to be qualified to give evidence on the issues I have been asked to consider. Aspects of my background and expertise that I believe to be relevant in that regard include:

   (a) I have held positions in the field of medical law and ethics for some 17 years, including having previously held the post of lecturer in Medical Law and Ethics at the University of Glasgow's school of law, and have been publishing in the area for the last 15 years.

   (b) As head of the New Zealand Law Foundation Centre for Law and Policy in Emerging Technologies, I direct an institution whose research focus is to examine the legal, ethical and policy issues around new technologies.

   (c) I have published a number of papers which consider the ethical, legal, and policy implications of end of life issues. My recent publications in this area are:

      (i) (with Hedley, H) 'Death and Dying – Legal Issues Elders may Encounter', in Diesfeld and McIntosh, eds. *Essentials of Elder Law in New Zealand* (ThompsonReuters, 2014);

      (ii) 'General end of life rights and ethical issues', chapter for Tolley's *Finance and Law for the Older Client*, 2008 (last revised, 2013);

      (iii) "In word, or sigh, or tear: Depression and end of life choices", in Laurie and Ferguson, eds. *Inspiring a Medico-Legal Revolution* (Ashgate, forthcoming June 2015).

3. A copy of my curriculum vitae is annexed as exhibit "**CG1**".

4. I have read the Code of Conduct for expert witnesses in Schedule 4 of the High Court Rules and agree to comply with it.

Issue addressed in affidavit

5. I have been asked to consider the question of whether there is a meaningful ethical distinction between current end of life practices and the aid in dying practices pleaded by the plaintiff in this case. Some of the defendant's witnesses maintain that there is such a clear distinction.[1] In the course of answering that question, my evidence addresses the following matters:

---

[1] For example, Affidavit of John Kleinsman at [37], [38] and [41]; Affidavit of Baroness Illora Finlay at [86]-[87].

HD. CG

(a) end of life practices commonly accepted as occurring in New Zealand now;

(b) the strength of the ethical bases on which one might distinguish those practices from either facilitated aid in dying or administered aid in dying; and

(c) the current weight of ethical opinion on the question.

6. In my view there is no meaningful ethical distinction. While philosophical distinctions may be identified at various levels of abstraction between these practices, the morally significant features of these practices are much more important, and do not lend themselves to ready distinctions.

7. I also address a further concern raised by the defendant's witnesses around the perceived ethical impact of permitting aid in dying on the medical profession.[2]

Current end of life practices

8. The following end of life practices appear to be currently recognised by medical bodies as appropriate end of life care in New Zealand and elsewhere:

(a) acceding to a patient's request to withdraw a treatment, knowing that death will result; and

(b) administering medications in doses that will hasten death, provided the intention is to ease pain (pursuant to the doctrine of double effect).

Withdrawal of life-preserving treatment

9. The withdrawal of life-preserving treatment is widely recognised as being acceptable, by courts,[3,4] professional bodies[5,6] and commentators in the field.

10. For example, the Australian and New Zealand Intensive Care Society's *Statement on Withholding and Withdrawing Treatment* states that the "withholding or withdrawing of specific treatments is appropriate in some circumstances", and those circumstances include where a competent

---

[2] For example, Affidavit of Roderick MacLeod from [61]ff; Affidavit of John Kleinsman at [102]-[103].

[3] See eg *Airedale NHS Trust v Bland* [1993] 1 All ER 821; *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449.

[4] In a NZ context, see *Auckland Area Health Board v Attorney-General* (1992) 8 CRNZ 634 (HC).

[5] "Some members of the healthcare team, or people who are close to the patient, may find it more difficult to contemplate withdrawing a life-prolonging treatment than to decide not to start the treatment in the first place. This may be because of the emotional distress that can accompany a decision to withdraw life-prolonging treatment, or because they would feel responsible for the patient's death. However, you should not allow these anxieties to override your clinical judgement and lead you either not to start treatment that may be of some benefit to the patient, or to continue treatment that is of no overall benefit." General Medical Council (UK), *Treatment and care towards the end of life: good practice in decision making* (May 2010), at para 33.

[6] "There is no ethical distinction between withdrawing and withholding life-preserving treatment." American Medical Association. Opinion 2.20 - Withholding or Withdrawing Life-preserving Medical Treatment.

cq

patient has made such a request "even if this may shorten their life".[7] It concludes:

> Withholding treatment and withdrawing treatment are legally and ethically equivalent. Decisions to withhold treatment should involve the same principles and processes as decisions to withdraw treatment. ... When death follows the withdrawal or withholding of treatment in accordance with the principles outlined in this statement, the cause of death is the medical condition that necessitates the treatment that is withheld or withdrawn.

11. This acceptance appears to be borne out in clinical practice. Clive Seale has conducted an influential series of studies into end of life decisions in practice. His survey of 2896 UK doctors revealed that 21.8% had withheld or withdrawn treatment with the knowledge of probable or certain hastening of end of life. Indeed, 4.9% did so with the explicit intention of hastening end of life.[8]

12. In 2003, a survey of 693 New Zealand general practitioners, published in the British Medical Journal, revealed that 37% believed they had probably hastened death by withholding treatment, and 29% by withdrawing treatment.[9] As in the UK study, a significant proportion had withheld (19%) or withdrawn (10%) treatment "with the explicit purpose of not prolonging life or hastening death."

Medications that will hasten death, administered with the intention of easing pain (double effect)

13. Professional bodies also endorse the provision of medications that hasten death, if the purpose for their administration is to alleviate pain.[10,11,12]

14. This practice appears to be widespread. Seale's UK research revealed that 15% of doctors had been involved in the alleviation of symptoms with "knowledge of probable or certain hastening of end of life." In the New

---

[7] College of Intensive Care Medicine of Australia and New Zealand and Australian and New Zealand Intensive Care Society. *Statement on Withholding and Withdrawing Treatment.* (2003, reviewed 2013).

[8] C Seale. End-of-life decisions in the UK involving medical practitioners. Palliative Medicine 2009; 23(3): 198-204.

[9] K Mitchell and R Glynn Owens. National survey of medical decisions at end of life made by New Zealand general practitioners. *British Medical Journal;* Jul 26, 2003; 327, 7408.

[10] "The use of medication for control of patient symptoms in this setting [when death is expected] is appropriate, even if this may shorten life." College of Intensive Care Medicine of Australia and New Zealand and Australian and New Zealand Intensive Care Society. *Statement on Withholding and Withdrawing Treatment.* (2003, reviewed 2013).

[11] 'If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide: ... the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.' Australian Medical Association, Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014).

[12] Certain bodies cited by the defendant's witnesses take positions to similar effect. See Affidavit of Dr Amanda Landers at [17], recording the New Zealand Medical Association position statement of 2005: "In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of that patient, is not unethical". See also Affidavit of Dr Sinead Donnelly at [44], recording at bullet 5 the position of the Palliative Care Council of New Zealand: "*believes* that if treatment appropriately titrated to relieve symptoms has a secondary and unintended consequence of hastening death that this is not euthanasia" (original emphasis).

cq

Zealand survey, almost 85% reported probably hastening death by intensifying pain relief.[13]

No meaningful distinction between aid in dying and withdrawal of life-preserving treatment

15. Various justifications have been offered for regarding the withdrawal of life-preserving treatment as ethically distinct from aid in dying:

(a) intention;

(b) the difference between acts and omissions;

(c) causation;

(d) patient autonomy; and

(e) avoiding harm (non-maleficence).

(a) Intention

The patient's intention

16. It is far from clear that patients withdrawing life-saving treatment will have different intentions from those seeking aid in dying. Many patients, including a number of patients who fought publicly for the right to have treatment withdrawn, will intend to die by those means.[14] The patient who asks to be permitted to starve to death seeks exactly the same result as the patient who wishes to drink a lethal drug. Clearly, many patients who have in the past chosen to starve or die by other means may have chosen aid in dying had it been available. Their intention is not altered by the change in mechanism by which their death is pursued.

17. The patient in *Re B* intended to die:[15]

> In many ways the decision to have my treatment withdrawn has been a very difficult one for me as I have been a Christian and a regular church attendee all my life. The dominant view in the church is that that I should wait for God to heal me. Withdrawing ventilation would be seen as throwing in the towel. I have questioned myself about this and it has challenged my integrity. It has been a very difficult process to rationalise what I am doing in the context of my faith but I feel there is no alternative, as I do not have any realistic hope of recovery. I have come to believe that people die and become disabled and God does not always intervene. It has also been difficult for me to contemplate leaving the people I love behind. There has been a lot of talking and crying as no one wants me to die but almost all of them empathise with me and my situation and sincerely wish to respect my wishes, which I have made clear to all.

---

[13] K Mitchell and R Glynn Owens. National survey of medical decisions at end of life made by New Zealand general practitioners. *British Medical Journal;* Jul 26, 2003 at 203.

[14] See, for example, the evident resolve of Margaret Page in refusing nutrition for the 16 days prior to her death in 2010: http://www.stuff.co.nz/the-press/news/3532462/Margaret-Page-dies-in-rest-home-after-16-days, annexed as exhibit "**CG2**".

[15] *Re B* at [52].

AHB CG

18. I can see no basis to say that Ms B did not intend to die, while someone like Gloria Taylor (a plaintiff in the *Carter* case) did so intend when she said:[16]

> I intend to get every bit of happiness I can wring from what is left of my life so long as it remains a life of quality; but I do not want to live a life without quality. There will come a point when I will know that enough is enough.

The physician's intention

19. As with the patient, there is nothing inherent in the mechanism by which death occurs in a withdrawal of treatment case (as opposed to aid in dying) that determines the intention of the doctor.

20. Further, the doctor's intention in withdrawal of treatment scenarios is not thought to be significant for the ethical legitimacy of that withdrawal. Although guidance from professional bodies often prohibits *actions* motivated by intent to bring about death, the same is not typically said of decisions to withdraw or withhold life-prolonging treatment.[17] This is perhaps unsurprising, in view of judicial acknowledgment that such intent may be present.[18] Indeed, as noted above, there is UK empirical evidence from Seale to suggest that a number of doctors identify themselves as intending death for the patients in withdrawal cases.

21. In aid in dying cases, there is also nothing inherent in the mechanism that determines the intention of the doctor involved. For example: (a) the doctor administering aid in dying may intend to alleviate the suffering experienced by the patient; and (b) in the facilitated aid in dying case, the doctor may even consider death a far from certain outcome.

22. So, in example (a), there seems little to separate the state of mind of the doctor administering aid in dying from the doctor withdrawing life-preserving medical treatment. Both do an act knowing that death will result. Both may do so with the primary intention of alleviating a patient's suffering.

23. In example (b), the doctor providing facilitated aid in dying may also act without a primary intention to cause death. He or she could, for example, prescribe life-ending drugs with the sole intention of alleviating a terminal patient's distress or suffering at the prospect of losing autonomy and dignity as death approaches, or of offering reassurance in the face of the patient's fear that their suffering might become intolerable, without any intention that the patient go on to ingest that drug (or indeed, even with the - quite plausible - hope that they do not).

24. Further, the doctor providing facilitated aid in dying may well be less certain about the outcome of his or her acts than a doctor withdrawing life-preserving treatment. The experience in Oregon between 1997 (inception of the Death with Dignity Act) and 2014 has been that

---

[16] *Carter* at [54].

[17] See, for example, General Medical Council (UK) Treatment and care towards the end of life: good practice in decision making (2010), at 80; British Medical Association End-of-life decisions (August 2009).

[18] See for example the withdrawal of treatment scenario approved by the House of Lords in *Airedale NHS Trust v Bland* [1993] 1 All ER 821, where a number of their Lordships were content to recognise the intention behind withdrawal in that case as being to precipitate Anthony Bland's death: at 880h per Lord Wilkinson; at 876e per Lord Lowry (recording counsel's argument without criticism).

approximately 35% of patients prescribed life-ending drugs did not end up taking them.[19] Accordingly, in contrast to the doctor who knows that withdrawing life-sustaining ventilation or hydration will result in the patient's death, there is no such certainty for the prescribing doctor in facilitated aid in dying cases. The patient's exercise of their own free will in choosing whether or not to take the life-ending drug is interposed between the physician's prescription and whatever consequences result for the patient. It is therefore entirely plausible that a physician in Oregon (or elsewhere) prescribing a life-ending drug may operate in a quite different state of mind to that of a physician removing a feeding tube.

25. Moreover, regardless of the doctor's actual intention and given the importance of autonomy in this context (which I explore below), it is not clear that the doctor's state of mind should matter in either the withdrawal of treatment or aid in dying case.

(b) Act / omission distinction

26. Any act / omission distinction collapses in the situation of doctor-led end of life care.

27. Philosophers can accept that where a patient refuses treatment, that there is an omission and that is different, in some sense, to an act. Philosophers certainly do not agree that the difference is morally relevant. There are many famous thought experiments designed to test the reasonableness of intuitions about omissions and commissions. Perhaps the most famous is from James Rachels,[20] whose "drowning nephew" thought experiment is widely taken to illustrate that an omission can, in some circumstances, be every bit as morally culpable as an act.

28. In Beauchamp and Childress' *Principles of Biomedical Ethics*, now in its seventh edition, and widely considered to be the most influential general text in the field, the authors express what is probably now the majority opinion in bioethics:[21]

> in short, the labels "killing" and "letting die," even when correctly applied, do not determine that one form of action is better or worse, or more or less justified, than the other. Some particular instances of killing, such as brutal murder, may be worse than some particular instance of allowing to die, such as forgoing treatment for a PVS patient; but some particular instance of letting die, such as not resuscitating a patient whom physicians could potentially save, also may be worse than some particular instance of killing, such as mercy killing at the patient's request. ... We need to know the circumstances, the actor's motive (e.g., whether it is benevolent or malicious), the patient's preferences, and the act's consequences. These

---

[19] Oregon Public Health Division, *Death with Dignity Act Annual Report Year 17* (12 February 2015)(https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf) at 2 (noting 859 persons have died in the period 1997-2014 from ingesting DWDA prescriptions out of the 1327 persons who have had prescriptions written).

[20] James Rachels asks us to imagine Smith sneaking into the bathroom and drowning his 6-year-old nephew in order to gain an inheritance, or Jones sneaking into the bathroom with the same intent, finding that the nephew has already fallen and struck his head, and standing by gleefully watching him drown, ready to intervene should that be necessary. Rachels invites us to share his conclusion that there is no real moral difference between the behaviour of Smith and that of Jones. Rachels J. Active and passive euthanasia. *New England Journal of Medicine* 1975; 292:78-80.

[21] TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Seventh Edition), Oxford University Press, 2013, at 176-177.

AHP cq

> additional factors will allow us to place the act on a moral map and make an informed normative judgment.

29. Whether or not the acts-omissions distinction has philosophical merit in the abstract – and as I have suggested, this is questionable - that enquiry is of limited relevance in many healthcare contexts:

    (a) Unlike the "bad Samaritan" of philosophical thought experiments, a doctor undoubtedly owes a duty of care to the patient. Hence, any decision that will result in the patient's earlier death requires a degree of justification, regardless of the nature of that decision.

    (b) Unlike the classic "omission" scenarios of moral philosophy, turning off a ventilator, or removing a feeding tube, requires a series of positive acts, each directed at bringing about the death of the patient. As such, it is questionable whether classifying such an intervention as an "omission" rather than an "act" is conceptually coherent. In the recent *Stransham-Ford* decision, Fabricius J accepted the common sense argument that:[22]

    > [w]here life sustaining or life prolonging treatment has been administered and is subsequently withdrawn, the act of withdrawal is nonetheless a commission - it remains an active and positive step taken by the medical staff directly causing the death of the patient (on a factual basis).

    (c) Even if the 'omission' description is appropriate, however, the necessity for such an active step means that responsibility, rather than being distributed among a potentially limitless class of non-actors (as in some cases of 'true' omissions), can be attributed more specifically to an identifiable agent. Similarly, as distinct from many 'true' omissions, the person whose life will be ended as a result of the decision is readily identifiable.

    (d) One argument sometimes relied upon in defence of the distinction relies on potentially dangerous consequences of allowing active killing. The argument holds that, while the opportunity to end life by omission is likely to arise only very rarely, allowing active killing could potentially endanger a much wider class of potential victims. It is doubtless true that most of us will rarely, if ever, find ourselves in a position where our actions may save a life, and hence, our opportunities to 'kill by omission' are very limited. This, however, is very different in the healthcare context, where many healthcare providers will encounter such situations on a daily basis.

30. Omissions are sometimes argued to be less culpable than acts, because they allow an existing state of affairs to continue, whereas acts create a state of affairs. This, it is sometimes thought, imposes a lesser obligation. While this may be true of certain examples of withholding treatment (subject to my reservation at paragraph 29(a) above), it is considerably more problematic in the context of decisions to withdraw treatment. Having modified the state of affairs (eg by introducing a ventilator), a doctor is not simply allowing the prior state of affairs to take

---

[22] *Stransham-Ford v Minister of Justice And Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230 (4 May 2015), at 31.

its course when he or she switches the ventilator off. This "argument from symmetry" – the idea that the doctor is merely undoing what s/he started, leaving the patient in the same position s/he would have been in had the doctor not intervened in the first place – is highly questionable. What truly justifies such an action is the patient's consent, or where that is not available, a good faith decision in his/her best interests. In the absence of these justifying conditions, no defence can be derived from the notion that what occurs is a mere omission.

31. I am aware that the law has in some cases defined those acts necessary to terminate life-preserving treatment as "omissions". While I appreciate the attractiveness of that classification for legal reasons, it appears to me to be a legal fiction designed to allow what those courts perceive to be humane medical practices to continue.[23] There is no coherent ethical distinction that can, in general terms, be drawn between switching off a ventilator and administering aid in dying.

(c) Causation

32. The argument from causation is that when treatment is withdrawn the underlying condition causes death; but that in aid in dying scenarios, the physician's assistance is the cause of death.

33. In an influential article, Miller, Truog and Brock assess this classification, comparing two hypothetical quadriplegic patients who wish to die. One of those (John) is dependent on a ventilator, and wishes to have this switched off; the other (Sam) is not dependent on a ventilator and requires unambiguously "active" assistance to die. The authors set out by acknowledging that:[24]

> According to conventional medical ethics, the withdrawal of life-preserving therapy allows the patient to die from his underlying spinal cord injury and inability to breathe spontaneously; it is an omission of treatment, not an act that causes the patient's death.

34. They proceed, however, to "conclude that it is a fiction to describe John's death following withdrawal of the ventilator as merely allowing him to die and not causing his death."

35. The notion that withdrawing treatment is merely allowing the underlying disease to take its course is problematic. For one thing, the cause of death will often not be a symptom of the disease itself – dehydration is not a symptom of tetraplegia or paralysis, and it is stretching logic and language to assert that it is. Moreover, the "underlying disease" argument is employed highly selectively; no-one, presumably, would contend that a member of the public entering an ICU and disconnecting life support apparatus would be doing anything other than causing death. While there is no doubt that such an interloper would be acting with a very different motive from the ethical practitioner, this does not go to causation. Causation is not normally thought to depend on the state of

---

[23] Miller FG, Truog RD, Brock DW. Moral fictions and medical ethics. *Bioethics* (2010); 24(9):453-460, at 456.

[24] Miller FG, Truog RD, Brock DW. Moral fictions and medical ethics. *Bioethics* (2010); 24(9):453-460, at 456.

mind of the actor. As Julian Savulescu, Uehiro Professor of Practical Ethics at the University of Oxford, has said: [25]

> The very same act is described in law as an "act" or an "omission", depending on whether or not a doctor performs it. Whether it is right or wrong might depend on whether a doctor performs it, but the nature of some physical event cannot logically depend on the identity of the person involved.

36. Further, not only does the underlying mechanism of death fail to distinguish withdrawal of life-preserving treatment cases from aid in dying cases, but no valid distinction is possible on the basis of causal proximity either, at least where facilitated aid in dying is concerned. The so-called "omission" of withdrawing treatment is often more proximate to, and more certain to result in, death than facilitated aid in dying. There can only be one outcome once a patient comes off a life-preserving ventilator or is sedated with a feeding tube removed. The act of writing the prescription does not cause death, and may very well (as the Oregon experience I have already referred to demonstrates) have no effect on the outcome of the patient's death.

37. Kennedy and Grubb are accordingly in orthodox territory in concluding that "[m]any moral philosophers" discount any moral difference between acts and omissions in the end of life context, "pointing out that omissions are as causally potent as actions and are therefore capable of bearing the same consequences for responsibility".[26] Similarly, the late David Thomasma – one of the leading figures in US bioethics – observed that "for the most part, ethicists and legal scholars have come to accept the notion that there is no morally significant difference between the decision to withhold or with draw treatment in order to let the patient die, and the decision to offer direct assistance in dying."[27]

38. Withdrawing life support can be good and ethical practice. In such cases, doctors will often have a lawful excuse in terms of sections 150A and 160 of the Crimes Act 1961, meaning that such withdrawal will not be culpable. The suggestion that the doctor's conduct has not caused the death of the patient is, however, entirely artificial.

(d) Autonomy

39. The refusal or withdrawal of treatment is sometimes justified by the autonomy principle.[28]

40. In essence, the principle of respect for autonomy reserves to the individual control over his or her body and over the most fundamental and meaningful choices and decisions available to a person. As how one dies is clearly one of those most fundamental and meaningful decisions, autonomy supplies a powerful ethical claim to respect for individual decisions and choices in the end of life context.

41. Contrary to some assertions from opponents, I am unaware of any credible account of autonomy that asserts that it "essentially knows no

---

[25] Savulescu J. Abortion, Infanticide and Allowing Babies to Die, 40 Years On. *Journal of Medical Ethics* (2013); 39(%): 257-259, at 257.

[26] Kennedy and Grubb, *Principles of Medical Law* (Oxford University Press, 1998) at 845.

[27] Thomasma DC, Assessing the Arguments for and against Euthanasia and Assisted Suicide: Part Two. *Cambridge Quarterly of Healthcare Ethics* (1998), 7, 388-401, at 393.

[28] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), at [16] - [21]. The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (November 2011) at 30.

A10 C9

limits."[29] Even John Stuart Mill, widely hailed as the foremost champion of personal liberty, recognised that this could legitimately be restrained to prevent harm to others.[30] But a serious commitment to respect for autonomy requires more than merely speculative or remote threats of such harm. Rather, the onus rests with those who would restrict autonomy to demonstrate a compelling need to do so. Further, criticisms of autonomy as reflecting a contested bias towards "an individualistic ethos" lack credibility in the healthcare context, where individual decisions over matters of the utmost significance to the individual enjoy clear and consistent priority.[31]

42. Respect for this orthodox account of autonomy is an ethical principle that is thus afforded primary importance in many healthcare contexts. Informed consent is the cornerstone of ethical treatment. For example, the autonomy principle can be seen to underpin the ethical duty on health care providers to provide patients with the necessary information about the options, risks and benefits of medical treatment; the patient's claim to autonomy is so significant that he or she must be provided with the informational tools necessary to support autonomous decision-making.[32]

43. Respect for autonomy also provides the ethical basis for the patient's recognised ability to refuse treatment. It justifies the requirement that life-preserving treatments be ceased or removed in accordance with a patient's wishes, even where those wishes override the legitimate desires of others (eg doctors' own views about the best interests of the patient, or the state's interest in the preservation of life). In this way, the principle of respect for autonomy trumps the principle of non-maleficence (that is, the avoidance of harm, assuming the ending of life at the patient's request could be considered harm).

44. Respect for autonomy provides an equally compelling justification for permitting aid in dying. The same principle that justifies the decision to withdraw life-sustaining treatment by reason of the patient's interest in controlling the last phase of life is engaged just as powerfully when one is not able to speed one's death by withdrawing treatment. Accordingly, applying the same account of the principle of autonomy consistently in both cases would require both a patient's treatment withdrawal decision and their aid in dying decision to be equally respected.

45. I note that sometimes a distinction is sought to be made on the basis that autonomy justifies only a right to refuse something rather than a right to demand something. Thus, it is argued that one may *refuse* treatment, but there is no correlative right to *receive* treatment. Regardless of whether that distinction can survive scrutiny, it does not apply to the plaintiff's claim here.

46. That is because the autonomy that the plaintiff wishes to exercise is in fact a negative right; she is demanding nothing from the state other than to be *allowed* to receive such help as she can locate. Her doctor is prepared to assist her provided the Court confirms she is not legally

---

[29] Affidavit of John Kleinsman at [47].

[30] Mill, JS. 'On Liberty', in Mary Warnock, ed. *Utilitarianism*, Collins Fount Paperbacks, 1979, at 135.

[31] Affidavit of John Kleinsman at [47]-[49].

[32] The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 6(2): Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

ALP 09

prohibited from doing so.[33] Contrary to John Kleinsman's view that a right "to demand something from someone else" is being claimed,[34] there is no question of the plaintiff requesting recognition of a corresponding ethical duty on doctors to supply aid in dying. It is true that the plaintiff needs assistance (in a practical sense), but that is also true of the patient who needs assistance to have treatment withdrawn. All of these cases concern people who cannot take matters entirely into their own hands. The attempt to describe someone like the plaintiff as claiming a different kind of autonomy interest depends entirely on the artificial distinctions addressed above in respect of acts / omissions. Patients like the plaintiff simply request that the state not prohibit a doctor, who is willing to provide such assistance, from assisting them to do that which the state has already said that they are free to do unaided. The distinction between positive and negative autonomy claims is well captured by Lord Kerr in *Nicklinson*:[35]

> This right against unjustified interference with the freedom 'to decide by what means and at what point his or her life will end' does not impose a positive duty on the state. For it to amount to a positive duty there would have to be some claim that the state was required to furnish the assistance, rather than merely tolerate it. There is no question of the appellants claiming that they should be assisted by the state to do what they want to do.

47. A further difficulty with distinguishing between withdrawal of life-preserving treatment and aid in dying should be noted. Limiting the expression of autonomy to the withdrawal of treatment scenario means that two patients suffering to the same degree from two (equally unchosen) illnesses, one dependent on life-preserving treatment and one not, will be left with markedly different ability to control the nature of their death. The patient on life-preserving treatment must have his autonomy respected, including by obtaining physical assistance to withdraw the treatment (for example, the removal of a ventilator or feeding tube). The patient who is not on such support must wait to die.

48. Such "inequalities of fate",[36] where the outcome depends on simple chance or "moral luck", suggests that any ethical principle being invoked to justify the distinction in outcome is flawed. This was powerfully illustrated in 2002 when two paralysed, but competent and intelligent, middle aged women in the UK sought court approval of their respective end of life choices. Whereas the woman known as Ms B was able to have her wishes upheld[37] – by virtue of being ventilator dependent – Diane Pretty – who was not dependent on a ventilator – was denied aid in dying,[38] and in fact is believed to have died in precisely the manner that she had sought to avoid.[39] While I understand the legal barrier that the UK courts relied upon, it is, I believe, impossible to identify a valid moral distinction between these two cases.

---

[33] Affidavit of [redacted] at [17].

[34] Affidavit of John Kleinsman at [59].

[35] *R (on the application of Nicklinson and another)* [2014] UKSC 38, at [329].

[36] Quebec Select Committee on Dying with Dignity, *Dying with Dignity Report* (March 2012) at 61.

[37] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).

[38] *R. (on the application of Pretty) v DPP* [2002] 2 F.L.R. 45.

[39] "Diane Pretty dies in the way she always feared" The Telegraph 13 May 2002.

49. Lady Hale, in a recent UK Supreme Court judgment, noted the difficulty in presenting a plausible ethical account of the distinction between these two scenarios:[40]

> While this distinction may make sense to us, it must often make little sense, especially to those who suffer the cruel fate of paralysis: those who can breathe without artificial help are denied a choice which those who cannot do so may make, should they wish to do so. For some of the people looking after them, it will be a mystery why they must switch off the machine or withdraw artificial nutrition and hydration if this is what the patient wants, but they may not painlessly administer a lethal dose of medication which the patient wants just as much.

50. If autonomy matters, it is hard to see why it provides an ethical justification enabling those "lucky enough" to have a condition which requires a ventilator to have their informed choice respected, while those who are not so reliant, do not. Both end of life choices involve the same level of informed consent by rational patients. Where the outcome sought by both patients is identical, one would ordinarily expect to see powerful countervailing ethical considerations to justify the inequality of treatment. I am not convinced that such justification exists.

51. It is sometimes said that the argument from autonomy is undermined by difficulties in determining the competence of the person making the request. As Baroness Finlay argues in her affidavit, "To end your life is the biggest decision that you could make and is cognitively demanding. But detecting cognitive impairment is very difficult."[41]

52. This fails to offer a credible reason to distinguish aid in dying from refusals of life-preserving treatment. Both decisions would necessitate a determination of competence, and it is not apparent why that decision would be less reliable in the aid in dying context than in the context where a patient refuses food and hydration or a blood transfusion. The difficulty of these decisions is not thought to provide an ethical basis for a blanket ban on all life-ending decisions; healthcare professionals are routinely trusted with them. Further, and to the extent that treating doctors have doubts about making particular competence or cognitive impairment decisions,[42] it is entirely reasonable for them to seek support and advice from specialists (eg from psychiatrists). I note in this regard that the plaintiff's doctor expressly envisages consulting with specialists as appropriate in the process for assisted dying.[43] If the Court itself had concerns, it could also be informed by such expert evidence as has occurred in difficult treatment refusal decisions.[44]

53. It is sometimes argued by medical practitioners that overriding patient autonomy can be justified on the basis that the patient will predictably change his/her mind at a later date, or be grateful that his/her wishes were overridden. The anecdote provided by Baroness Finlay at paragraph [18] of her affidavit is a case in point. In some cases, this derives from a belief that the patient lacks personal experience of a

---

[40] *R (on the application of Nicklinson and another)* [2014] UKSC 38, at [304].

[41] Affidavit of Baroness Ilora Finlay, at [34].

[42] Affidavit of Baroness Ilora Finlay, at [34]-[35].

[43] Affidavit of [redacted] at [17].

[44] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819; *The NHS Trust v Ms T* [2004] EWHC 1279; *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); *Chief Executive of Department of Corrections v All Means All* [2014] NZHC 1433.

procedure or a condition, and that it follows that their decision cannot be properly informed.

54. This sort of benevolent paternalism can also arise in the context of treatment withdrawal. In the *Ms B* case, the surgeon referred to as Mr G gave evidence to the effect that:[45]

> He thought that it would take up to two years to gain the experience necessary to have an informed opinion. Patients in the position of Ms B, in his view, could only appreciate fully through experience.

55. This requirement was rejected by the judge,[46] but it is also difficult to see how it could be sustained in practice. By definition, life or death decisions involve making decisions about that of which we can have no direct experience. Furthermore, in ethical terms, respect for autonomy would count for very little were it able to be overridden in any instance where medical staff believed they simply knew better than a competent patient. It is no answer to competent patients who wish to have their life-preserving ventilators withdrawn that their decisions cannot be trusted or implemented because the doctor's experience indicates that they will in fact grow to appreciate the ventilator. Such benevolent paternalism, while doubtless well intentioned, is incompatible with modern ethical standards.

56. It is sometimes argued that aid in dying cannot be a truly autonomous choice, as – by definition – it necessitates the involvement of others. In his affidavit, John Kleinsman argues that:[47]

> It is logically incoherent, therefore, to argue that access to assisted suicide or euthanasia should be justified on the basis of individual choice when they require both the assistance of another or others and the authorization of the state...

This, for Kleinsman, allows him to conclude that these practices "do not fall within any valid definition of autonomy".

57. It is unclear which concept of autonomy Dr Kleinsman is seeking to utilize here. Certainly, it would seem to be a very restricted notion that encompassed only such choices that could be undertaken without any support or assistance from others. No surgery, for instance, could be justified by reference to autonomy. Neither, of course, could a demand by a paralysed person to have life-prolonging treatment ceased. As previously noted, alternative conceptions of autonomy like Dr Kleinsman's have little purchase in the healthcare context.

58. Finally, in this regard, I note that whatever doubts that some of the defendant's witnesses may hold as to the truly autonomous nature of the plaintiff's decision in the present case, it is surely more secure than in many cases in which patients lives have been ended by cessation of life-prolonging treatment. The High Court of New Zealand has, for example, permitted the removal of ventilatory support from a patient who, while still believed to be aware, was "unable to communicate by even elementary means",[48] and similar decisions have been reached by UK courts.[49]

---

[45] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), at [62].

[46] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), at [63].

[47] Affidavit of John Kleinsman, at [57].

[48] *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 (HC) at 238.

[49] For example, *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129

59. In addition, decisions are regularly made to withhold or remove life support from patients who are permanently unconscious or otherwise incompetent, and thus incapable of holding or expressing any autonomous views.[50] Whatever differences may be thought to exist between such cases and the provision of aid in dying, I do not see how they can derive from the patient's autonomy being better safeguarded in the former case than in the latter.

(e) Avoiding harm (non-maleficence)

60. While respect for autonomy has been accorded primacy in the context of treatment refusals, it is worth touching briefly on another important bioethical principle at play here: that of non-maleficence, or the avoidance of harm.

61. The avoidance of harm is frequently invoked by both sides in the "aid in dying" debate. I have already explained how, at the operational level, non-maleficence yields to autonomy in the case of the withdrawal of treatment. There is no basis for a lesser weight to be assigned to autonomy in the case of aid in dying, where the perceived harm (in the form of the patient's death) may be just as likely, or even less likely in the case of facilitated aid in dying, to result from the doctor's actions.

62. However, opponents of aid in dying also routinely invoke the principle of non-maleficence in respect of a suggested systemic harm to be avoided, in the form of alleged risks to vulnerable populations. Indeed, such concerns, rather than overtly theological or deontological values, are probably the most common reason given for opposition to assisted dying. For example, John Kleinsman was recently at pains to point out publicly that 'I am, in all honesty, not interested in imposing my religious views on anyone', but rather, indentified that his argument against assisted dying 'centres on safety and protection of those who are vulnerable.'[51]

63. Whether such concerns have any empirical foundation, and if so, to what degree, is a matter for those who rely on them to establish through appropriate evidence. From the perspective of ethics, however, I note that it is impossible to discern any different *kind* of threat to the vulnerable in aid in dying cases than already exists in the context of treatment refusals. Baroness Finlay thus raises a number of concerns about aid in dying regimes based on alleged diagnostic and prognostic uncertainty, the potential for coercion, the potential for doctors to communicate worthlessness, the inability of doctors to diagnose depression or assess mental competence, and the instability of end of life choices.[52] I do not make any comment about the empirical plausibility of these claims or how applicable they may or may not be to the plaintiff's situation. Importantly, however, each of these concerns has the same potential to apply to decisions around the withdrawal of life-preserving treatment, yet those risks are not thought to present sufficient basis for a blanket ban on treatment refusals or other withdrawals of life-prolonging treatment. Rather, medical professionals are entrusted with the responsibility of safeguarding their patients from such harms.

---

[50] For example, *Airedale N.H.S. Trust v. Bland* [1993] 2 W.L.R. 316; *Re D* [1998] 1 FLR 411 Fam Div; *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67,

[51] Kleinsman, J. 'Legal euthanasia kills justice for all' *Sunday Star Times*, 6 May 2012.

[52] Affidavit of Baroness Illora Finlay.

AfD Q9

64. Indeed, it has been suggested that the status quo, which allows doctors to withdraw life-prolonging treatment even from incompetent patients, presents considerably greater risks to vulnerable people than a scheme of assisted dying which focused on capacity and autonomy. As LSE Professor Emily Jackson has said:[53]

> It could, in my view, plausibly be argued that the lawful ways in which doctors may shorten their patients lives are not only more common but also might be more open to abuse and likely to lead to more protracted deaths than assisted dying.

65. Further, any balanced application of the principle of non-maleficence in this context also needs to consider the systemic harms involved in drawing a distinction between withdrawal of treatment and aid in dying, namely the suffering of dying persons like the plaintiff that results. As the plaintiff's own evidence makes clear, such a distinction forces patients to endure more suffering than they need to on the path to death. The conclusion in *Re B* provides an example of how easy it is to lose sight of those harms:[54]

> I have to say, with some sadness, that the one-way weaning process appears to have been designed to help the treating clinicians and the other carers and not in any way designed to help Ms B. If the one-way weaning process were to be carried out as suggested by the doctors, there would be a risk that she would die in discomfort and possibly in pain, even though that is not what they intended. It was obviously, to anyone looking at it from outside the hospital, an unrealistic and unhelpful programme.

No meaningful distinction between treatment in accordance with the "double effect" doctrine and aid in dying

66. The doctrine of double effect ("**DDE**") can take several forms, but in its classic iteration, it consists of four elements:

(1) The act itself must be morally good or at least indifferent.

(2) The agent may not positively will the bad effect but may permit it. If he could attain the good effect without the bad effect he should do so.

(3) The good effect must flow from the action at least as immediately (in the order of causality, though not necessarily in the order of time) as the bad effect. In other words, the good effect must be produced directly by the action, not by the bad effect. Otherwise the agent would be using a bad means to a good end, which is never allowed.

(4) The good effect must be sufficiently desirable to compensate for the bad effect.

67. Those courts which have referred to the DDE have not invariably invoked each of these requirements, and some courts have added additional

---

[53] Jackson E. *Medical Law: Text, Cases, and Materials*. Second edition. Oxford: Oxford University Pres, 2010, at 952.

[54] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), at [98].

requirements. Nonetheless, in ethical discourse, the four elements are widely regarded as being necessary.[55]

68. DDE relies in essence on a distinction between intention and foresight of likely or even certain outcomes.[56] It argues that what is morally salient is the doctor's intention in treating the patient (eg to alleviate suffering), not the foreseen consequences of that course of action (which may include, in the case of certain medicines, the hastening of death).

69. As I noted earlier, 85% of New Zealand doctors surveyed reported using pain relief in the expectation that it would probably hasten death.[57] The DDE is the traditional justification for such practices.

70. Again, however, there is no real distinction on analysis between that practice and facilitated aid in dying. As I have noted earlier, doctors providing facilitated aid in dying, for example, may write scripts for life-ending drugs without intending the death of their patient. Like the palliative care doctor relying on DDE to administer analgesia, they may well intend only to alleviate suffering - whether it is the pain and suffering caused to the terminal patient by their illness, and/or the psychological suffering that may be experienced where that patient lacks the "insurance policy" of a life-ending drug as their condition deteriorates.

71. A simple cross-check is often employed to test an actor's "true" intention and thus compliance with the doctrine of double effect. The "test of failure"[58] asks whether the actor would be happy with the result if only the intended, and not the "merely foreseen" outcome, eventuated. There is no inherent reason why facilitated aid in dying would fail this test. The facilitated aid in dying doctor would no doubt be satisfied if the patient prescribed a life-ending drug died without suffering intolerably (the intended outcome), without ever having to utilise the prescribed drug (the potentially foreseen consequence). Indeed, as the Oregon experience demonstrates, the prescribing doctor may even lack certainty regarding the foreseen outcomes in facilitated aid in dying, given that the prescription of a life-ending drug does not result, in more than a third of cases, in the ingestion of that drug.

72. Overall, it should be noted that any distinction made between the various end of life practices pursuant to this doctrine is exceedingly fine. In the context of intimate end of life choices where patient autonomy has the strongest moral claim, it has rightly been described as "to split hairs".[59]

---

[55] Uniacke, S. 'The Doctrine of Double Effect.' In Ashcroft R, Dawson A, Draper H, McMillan J, eds. *Principles of Health Care Ethics* (2nd ed.) Hoboken: Wiley 2007, at 265. Foster C, Herring J, Melham K, Hope T. 'The Double Effect Effect.' Cambridge Quarterly of Healthcare Ethics (2011), 20, 56–72. Keown J. *Euthanasia, Ethics and Public Policy.* Cambridge: Cambridge University Press; 2002, at 20.

[56] See for example The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (November 2011) at 49: "The argument from the DDE [doctrine of double effect] relies on accepting a further concept, namely the IFD [intention-foresight distinction]. This distinction upholds the view that there is a moral difference between intending a patient's death and foreseeing that it might happen, but not intending for it to happen".

[57] K Mitchell and R Glynn Owens. National survey of medical decisions at end of life made by New Zealand general practitioners. *British Medical Journal;* Jul 26, 2003 at 203.

[58] Uniacke, S. 'The Doctrine of Double Effect.' In Ashcroft R, Dawson A, Draper H, McMillan J, eds. Principles of Health Care Ethics (2nd ed.) Hoboken: Wiley 2007, at 266.

[59] The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (November 2011) at 49.

73. Further, to the extent that it is difficult to separate the identification of intentions from known consequences,[60] such distinctions might also be thought to be rather too nice to provide reliable guidance to practitioners. In the applied context of end of life decision-making, where ethical parameters must be capable of ready application to be of any value to doctors and patients alike, this suggests a failure to keep sight of first principles.

The application of my ethical analysis to the case of palliative or terminal sedation

74. Palliative sedation is a practice which involves administering drugs at such a dosage that the patient is effectively left permanently unconscious. It may be accompanied by the withdrawal of other life sustaining treatments, including liquids and nutrition. That is how the practice was described in the trial evidence in the Canadian *Carter* litigation.[61]

75. I consider this practice separately in my evidence because its parameters are not always agreed. That can be seen in the evidence in this case. For example:

    (a) Dr Jack Havill, a New Zealand-based intensive care specialist, refers to his experience of deep sedation having complications which hasten death,[62] and notes that "[a]rtificial administration of food and fluid is usually withdrawn at the same time sedation is started".[63]

    (b) Dr Elizabeth Smales, a New Zealand-based palliative care physician, notes that in her experience, a patient given palliative sedation has "[o]ften ... already stopped eating or drinking ... [and are] too ill and tired to want food and drink".[64]

    (c) Professor Michael Ashby, a former Chairman of the Chapter of Palliative Medicine at the Royal Australasian College of Physicians, describes palliative sedation as "being a significant and well-accepted part of palliative care practice", used most often in the terminal phase of a dying patient's care, whereby "drug doses are titrated to induce relaxation, but this often results in sleep or a state of deep, continuous unconsciousness until the time of death".[65]

    (d) Baroness Finlay, a palliative medicine consultant in the UK, considers that Dr Ashby's description of the way in which sedation should be used is more accurate than the account by Dr Smales.[66] Elsewhere, however, Baroness Finlay appears to reject the use of sedation for anything other than short term, low

---

[60] "A person's exact motives are often somewhat opaque even to that individual; it would be wrong to ascribe complete reliability to the agent's capacity to know with complete certainty whether something that he or she knew would happen as a result of his or her action formed no part of the reason for which he or she did it." The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (November 2011) at 49.

[61] *Carter v Canada (Attorney-General)* 2012 BCSC 886 at [200].

[62] Affidavit (No 2) of Jack Havill at [10].

[63] Affidavit (No 2) of Jack Havill at [58].

[64] Affidavit of Elizabeth Smales at [28].

[65] Affidavit of Michael Ashby at [38].

[66] Affidavit of Baroness Ilora Finlay at [125].

dose pain relief, not to be used so as to lead to the patient's unconsciousness.[67]

(e) Simon Allan, the Director of Palliative Care at a New Zealand hospice, notes that what he calls "terminal sedation" may be applied where the situation becomes unbearable in the final few days before death. That practice involves sedation "titrated to a point of comfort for the patient and this is usually at a level where they are no longer or only minimally conscious as the dying process occurs". He notes that it "is unusual in cases of terminal sedation to offer artificial means of nutrition or hydration", such that the patient will "have a degree of dehydration contributing towards death". The "prime decision maker is the patient when competent to do so", and the "prime motivation for terminal sedation is that of comfort care, not the taking of life".[68]

76. It is not within my expertise to adjudicate on how palliative sedation is practised in New Zealand.

77. From an ethical perspective, I simply note that, to the extent palliative sedation is thought to hasten death in the pursuit of the primary goal of alleviating suffering, it conforms in type to medical treatment presently justified in New Zealand under the doctrine of double effect. In that regard, as I have explained above, there is no ethical difference between such treatment and facilitated aid in dying.

78. Further, to the extent that some palliative sedation practice involves the withdrawal of hydration or nutrition, it conforms in type to the account of the withdrawal of life-preserving treatment I have given above. In my view, as I have explained, none of the ethical bases that are offered to distinguish such withdrawal from aid in dying are convincing.

A substantial body of ethical opinion considers aid in dying is ethical

79. As will be apparent from the above, I consider that there is no compelling ethical distinction between current end of life practices and the aid in dying pleaded in the present case.

80. I note that similar conclusions have been reached by bodies or authors who constitute a substantial body of ethical opinion in the area:

(a) The Quebec Select Committee on Dying with Dignity concluded that the lines between aid in dying and existing Canadian end of life practices were "very fine" and "very murky",[69] and recommended legislative reform, which has now occurred.

(b) The Royal Society of Canada's expert panel concluded that it was ethical to permit aid in dying.[70]

---

[67] Affidavit of Baroness Illora Finlay at [109]-[111].

[68] Affidavit of Simon Allan at [17]-[23].

[69] Quebec Select Committee on Dying with Dignity, *Dying with Dignity Report* (March 2012) at 61-62.

[70] The Royal Society of Canada Expert Panel, "The Ethics of End-of-Life Care" (ch 3) in *End-of-Life Decision Making* (November 2011).

A10 09

(c) The Commission on Assisted Dying, convened by Lord Falconer, concluded that reform was desirable,[71] and a bill is currently before the UK parliament.

(d) While it is impossible to identify an ethical consensus on end of life issues, a number of influential publications in the early part of the 21st Century have reached conclusions similar to those expressed here.[72,73]

(e) In recent years, an increasing number of judges have expressed concern or dissatisfaction with the logic and ethics underpinning certain legal distinctions in end of life law.[74,75,76]

Ethical impact of aid in dying on the medical profession

81. In addition to concerns about threats to vulnerable people (addressed from paragraph 62 of my evidence above), it appears that opposition to aid in dying quite often derives from concerns about the integrity of the medical profession.[77]

82. For example, the report of the House of Lords Select Committee on Assisted Dying explained this concern as follows:[78]

> On the one side, it has been suggested that the legalisation of medical assistance for suicide and voluntary euthanasia could introduce a sense of distrust of doctors on the part of patients. On the other side, it is clear that many doctors are concerned that the introduction of assisted suicide and voluntary euthanasia as medical procedures could not only undermine their patients' trust in them but also run counter to the ethics of their profession.

---

[71] Report of The Commission on Assisted Dying, 2012, available at http://www.demos.co.uk/publications/thecommissiononassisteddying.

[72] In *Assisted Dying: Reflections on the Need for Law Reform* (winner of the 2008 Minty Prize of the Royal Society of Authors and the Royal Society of Medicine), Professor Sheila McLean argues that: "Refusing life-sustaining treatment and asking for assistance in dying are essentially indistinguishable – unless we resort to sophistry. Consistency and principle would therefore require that they be treated in the same way. (Routledge-Cavendish, 2007), at 101.

[73] Professor Hazel Biggs of Southampton University concludes her book with the proposal that "a gradual relaxation of the present legal restrictions could facilitate a highly regulated system of medically assisted dying for those who require it, while providing a high level of protection for everybody. ... Ultimately a more dignified alternative could be accessible to those who seek euthanasia for themselves and those who practice it." H Biggs, *Euthanasia: Death with Dignity and the Law* (Portland: Hart Publishing, 2001) at 173-174.

[74] See, for example, *R (on the application of Nicklinson and another)* [2014] UKSC 38, in particular, the judgments of Lord Neuberger, Lady Hale and Lord Kerr.

[75] *Carter v Canada* (Attorney General), 2015 SCC 5.

[76] The most recent common law judge to express scepticism about the traditional ethical distinctions in this area was Fabricius, J in the High Court of South Africa: 'In his replying affidavit Applicant himself said that there is no logical ethical distinction between the withdrawing of treatment to allow "the natural process of death" and physician-assisted death. He also called this distinction "intellectually dishonest". There is much to be said for this view but I best leave it for the philosophers, and confine myself to the constitutional debate.' *Stransham-Ford v Minister of Justice And Correctional Services and Others* (27401/15) [2015] ZAGPPHC 230 (4 May 2015), at 15.

[77] M Pabst Battin. *Ending Life: Ethics and the Way We Die*. New York: Oxford University Press, 2005, at 18.

[78] HL Select Committee on Assisted Dying for the Terminally Ill Bill First Report (2004-5), at [104].

83. The defendant's witnesses raise similar concerns about the impact on patient trust[79] and on medical practitioners / ethics.[80]

84. As the House of Lords Select Committee went on to note, however, "Opinion polls do not suggest any significant anxiety on this score from the point of view of patients".[81] Furthermore, as Emily Jackson has explained, there is no reason to suspect that aid in dying will generate greater fear from patients than is generated by the prospect of non-treatment decisions.[82] Indeed, the widespread concern generated by the controversial Liverpool Care Pathway for the Dying Patient (LCP) in the UK suggests that patient confidence can readily be undermined by lack of trust in the basis for non-treatment decisions.[83]

85. The LCP was "an approach to care, including a complex set of interventions, that resulted from a desire to replicate within the hospital sector the standard of care for the dying found in many hospices."[84] Following a series of alarming stories in the media, the Department of Health commissioned a Report into the LCP. The Report made numerous observations and recommendations about the LCP, but of relevance to the issue under discussion, it concluded that for many families, the end of life care received by their relatives had given rise to suspicion and mistrust:[85]

> Whether true or not, many families suspected that deaths had been hastened by the premature, or over-prescription of strong pain killing drugs or sedatives, and reported that these had sometimes been administered without discussion or consultation. There was a feeling that the drugs were being used as a "chemical cosh" which diminished the patient's desire or ability to accept food or drink. The apparently unnecessary withholding or prohibition of oral fluids seemed to cause the greatest concern.

86. While it is to be hoped that transparent decision-making and clear communication could avoid many such problems, this example makes clear that erosion of trust in end of life decisions cannot be avoided simply by adhering to any putative "bright line", between acts and omissions or intent and foresight. If families feel that their relative's life ended prematurely, without proper consultation or consent, or with insufficient regard to their dignity or well-being, their trust in end of life care will be undermined. Good practice and open communication will hopefully avoid, or at least minimise, such occurrences. Arbitrary lines will not.

---

[79] For example, Affidavit of Roderick MacLeod from [61]ff.

[80] For example, Affidavit of John Kleinsman at [102]-[103]; Affidavit of Baroness Illora Finlay at [61].

[81] HL Select Committee on Assisted Dying for the Terminally Ill Bill First Report (2004-5), at [105].

[82] E Jackson. Death, Euthanasia and the Medical Profession. In: Brooks-Gordon, et al, eds. *Death Rites and Rights*. Portland: Hart Publishing, 2007, at 39.

[83] Department of Health. *More Care, Less Pathway: A Review of the Liverpool Care Pathway*. 2013.

[84] Department of Health. *More Care, Less Pathway: A Review of the Liverpool Care Pathway*. 2013, at 3.

[85] Department of Health. *More Care, Less Pathway: A Review of the Liverpool Care Pathway*. 2013, at 3-4.

87. In addition, as several courts have noted,[86] it is unlikely that many patients or carers actually understand the fine distinctions that this argument is intended to uphold. If many or most laypersons already regard treatment withdrawal or "double effect" as acts of killing – or the ethical equivalent thereof – it is difficult to see how their trust in the medical profession could be undermined by the erosion of a distinction that they do not currently recognise.

88. An alternative account of the argument from professional integrity is concerned less with the perceptions of patients, and more with those of doctors. Former palliative care physician David Jeffrey has argued in defence of the acts-omissions distinction on the basis that it affords a form of emotional defence to practitioners:[87]

> If there was no distinction between killing and letting die, doctors would feel morally and physically responsible for the death of many patients. Doctors should be able to discontinue futile treatments without feeling responsible for the death of the patient.

89. It also appears that not all medical practitioners take comfort in the acts-omissions distinction, in the manner envisioned by David Jeffrey. In the *Ms B* case, the doctor referred to as Dr C gave evidence that she did not find the distinction comforting: "[s]he did not feel able to agree with simply switching off Ms B's ventilation. She would not be able to do it. She felt she was being asked to kill."[88]

90. Leaving aside the question of whether the priority in end of life choices should be the psychological comfort of doctors as opposed to patients, it is questionable why the permissibility of aid in dying would not obviously impose any additional emotional burden on those who elected only to continue with their previous practices. Those who believe treatment withdrawal to be permissible, but aid in dying to be impermissible, could continue to practice on that basis.

91. Pending the Supreme Court's decision in *Carter*, the Canadian Medical Association modified its Policy on euthanasia and assisted death. Its Policy statement now reads as follows:[89]

> There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate. The CMA supports patients' access to the full spectrum of end of life care that is legal in Canada. The CMA supports the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying as defined in this policy.

---

[86] See, for example, *R (on the application of Nicklinson and another)* [2014] UKSC 38, at [304].

[87] Jeffrey, D. *Against Physician Assisted Suicide. A palliative care perspective*. (Oxford: Radcliffe Publishing, 2009), at 43.

[88] *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), at [57].

[89] CMA Policy: Euthanasia and Assisted Death (Update 2014), available at https://www.cma.ca/Assets/assets-library/document/en/advocacy/EOL/CMA_Policy_Euthanasia_Assisted%20Death_PD15-02-e.pdf

I can think of no reason why the integrity of the medical profession, and the consciences of individual practitioners, would not be safeguarded by the adoption of a similar position here.

Conclusions

92. I conclude that there is no compelling ethical distinction between the aid in dying practices pleaded in this case and current end of life practices in New Zealand. Further, when measured against the ethical yardstick of autonomy that enjoys primacy in the health care context, aid in dying and current medical practices are identical in giving effect to a terminal patient's voluntary, competent and informed choices.

AFFIRMED at Dunedin this 15th day of May
May 2015 before me:

Colin James Gavaghan

A solicitor of the High Court of New Zealand / [✓ A Justice of the Peace]

A.R. Day
4240
DUNEDIN
Justice of the Peace for New Zealand

ARD CG

"CG1"

Curriculum vitae

Associate Professor Colin Gavaghan
LL.B. (Hons), Ph.D.
Director of New Zealand Law Foundation Centre for Law & Policy in Emerging Technologies
University of Otago

This is the annexure marked **"CG1"** referred to in the affidavit of **Colin James Gavaghan** affirmed at Dunedin this 15th day of May 2015 before me

Signature ....
A Solicitor of The High Court of New Zealand / [✓ A Justice of the Peace]

A.R. Day
4240
DUNEDIN
Justice of the Peace for New Zealand

Qualifications

LLB(Hons)	University of Glasgow 1992
Dip.L.P	University of Glasgow 1993
PhD	University of Glasgow 2007

Employment History

Present Position

Associate Professor, Faculty of Law, University of Otago
Director of NZLF Centre for Law & Policy in Emerging Technologies
Co-director of the Centre for Society, Governance & Science, University of Otago

Academic employment History

1998-2009	Lecturer, School of Law, University of Glasgow
1995-1998	Research assistant, Scottish Voluntary Euthanasia Society

Research Activities

Research Grants

2010 - $26,000 from Ministry of Research, Science & Technology, to review applicability and adequacy of existing regulatory mechanisms to manufactured nanomaterials

2013 - $17,500 from New Zealand Law Foundation for workshop, Select Committee submission and report into preventive detention in New Zealand.

Publications

Books

Defending the Genetic Supermarket: the law and ethics of selecting the next generation, RoutledgeCavendish, 2007.

Major Reviews

(With Jennifer Moore) *Review of the Adequacy of New Zealand's Regulatory Systems to Manage the Possible Impacts of Manufactured Nanomaterials*. Published at http://www.msi.govt.nz/sites/all/files/u4/Nanotechnology%20review.pdf. (120 pages)

(With Jeanne Snelling and John McMillan) *Better and Better and Better? A Legal and Ethical Analysis of preventive detention in New Zealand* (November 2014) (95 pages)

Book Chapters

(with Holly Hedley) "Death and Dying – Legal Issues Elders may Encounter" in K Diesfeld and I McIntosh (eds) *Essentials of Elder Law in New Zealand* (Wellington, ThompsonReuters, 2014) at 111-146.

"Public Voices or Private Choices? The Role of Public Consultation in the Regulation of Reproductive Technologies" in K O'Doherty and E Einsiedel (eds) *Publics and Emerging Technologies: Cultures, Contexts, and Challenges* (Vancouver, UBC Press, 2013) at 80-97.

"Neuroscience, Deviant Appetites, and the Criminal Law" in NA Vincent (ed) *Neuroscience and Legal Responsibility* (New York, Oxford University Press, 2013) at 205-226.

"General end of life rights and ethical issues" in Tolley's *Finance and Law for the Older Client*, 2008 (last revised, 2013).

"Regulating after Parfit: Welfare, Identity and the UK Embryology Law" in M Goodwin, BJ Koops and R Leenes (eds) *Dimensions of Technology Regulation*, (Wolf Legal Publishers, 2010) at 147-165.

"'No gene for fate'? Luck, Harm and Justice in Andrew Niccol's Gattaca" in S Shapshay (ed), *Bioethics at the Movies* (Baltimore, Johns Hopkins University Press, 2009) at 75-87.

Refereed Journal Articles

"Saviour siblings: no avoiding the hard questions" *Journal of medical ethics*, Published Online First 30 April 2015

(with A Bastani) "Genes, Blame and Loss of Control: Is There a Place in Criminal Law for a 'Genetic Defense'?" (2014) 8(2) *Recent Adv DNA Gene Seq.* 119-125.

(With M King and J McMillan) "Medical regulation of cognitive enhancement devices: some concerns" (2014) 1(3) *Journal of Law and Biosciences* 334-339.

(with M King) "Reporting suicide: safety isn't everything" (2013) 5(1) *Journal of Primary Health Care* 82–85.

(with J Moore) "De minimis curat lex: New Zealand law and the challenge of the very small" (2011) 2(3) *European Journal of Law & Technology* available online at http://ejlt.org//article/view/97

"A whole new ... you? 'Personal identity', genetics and the enhancement question" (2010) 3 *Identity in the Information Society* 423-434.

"'You can't handle the truth'; medical paternalism and prenatal alcohol use" (2009) 35(5) *Journal of Medical Ethics* 300-303.

"Disability, identity and choice: embryo testing and the Human Fertilisation and Embryology Act 2008" (2009) 9(3) *Contemporary Issues in Law* 133-153.

"End of life decision making in the context of UK law" (2008) 14 *Revista de Direito Médico e da Saúde* 111-130.

"Dangerous patients and duties to warn: a European Human Rights perspective" (2007) 14(2) *European Journal of Health Law* 113-131.

"Right problem, wrong solution: A pro-choice response to 'expressivist' concerns about preimplantation genetic diagnosis" (2007) 16(1) *Cambridge Quarterly of Healthcare Ethics* 20-35.

"A *Tarasoff* for Europe? A European Human Rights perspective on the duty to protect" (2007) 30 *International Journal of Law and Psychiatry* 255-267.

"'Designer donors'?: Tissue-typing and the regulation of pre-implantation genetic diagnosis" (2003) 3 *Web Journal of Current Legal Issues*

"Use of preimplantation diagnosis to produce tissue donors: an irreconcilable dichotomy?" (2003) 6 *Human Fertility* 23-25.

"Anticipatory Refusals and the Action of Wrongful Living" (2000) 5(1) *Medical Law International* 67-80.

"Deregulating the Genetic Supermarket: Pre-implantation Screening, Future People and the Harm Principle" (2000) 9(2) *Cambridge Quarterly of Healthcare Ethics* 242-261.

Edited

(With P Larrieu and B Roullet) *Neuroloex Sed ... Dura Lex? L'impact des neurosciences sur les disciplines juridiques et les autres sciences humaines: etudes Compares* (2013) Published by the Comparative Law Journal of the Pacific, in conjunction with the New Zealand Association for Comparative Law.

In press

"In word, or sigh, or tear: Depression and end of life choices", in G Laurie and P Ferguson (eds) *Inspiring a Medico-Legal Revolution* (Ashgate, forthcoming May 2015) (with J Snelling) "PGD Past, Present and Future: is the HFE Act 1990 now 'fit for purpose'?'" in K Horsey (ed) *Human Fertilisation and Embryology: Regulation Revisited* (Routledge, forthcoming 2015)

Submissions to Select Committees, etc

February 2014 – sole authored submission to Justice and Electoral Committee on the Harmful Digital Communications Bill

December 2013 – oral submission (with John McMillan and Armon Tamatea) to Justice and Electoral Select Committee on the Public Safety (Public Protection Orders) Bill

November 2013 – multi-authored submission to Justice and Electoral Select Committee on the Public Safety (Public Protection Orders) Bill

Other publications

December 2012 – present: various posts on Emerging Technologies Centre blog (https://blogs.otago.ac.nz/etc/)

(with O'Donnell, C) 'Money oil and angel powder: when medical law meets mad beliefs' *New Zealand Skeptic*, Issue 106 (Summer 2012-13): 3-7

'Don't overstate the risks of drinking while pregnant', *Bionews Commentaries*, March 2010

'Choosing children: Reflections on the regulation of embryo testing', *BioNews Commentaries*, March 2008

'Embryo testing: Why drawing lines risks devaluing the disabled.' *BioNews Commentaries*, March 2007

Book reviews

Review of Griffiths and Weyers, 'Euthanasia and Law in Europe', *Edinburgh Law Review* (2009): 13(3): 360-362

Review of Atkinson, J.M. 'Advance Directives in Mental Health: Theory, Practice and Ethics', *Ethics and Social Welfare* (2008); 2(3).

'Of bread and caviar': review of From the Womb to the Tomb' *Variant*, Issue 31, Spring 2008 (c.4000 words)

Review of 'Genetics and Gene Therapy', *Medical Law International* (2006); 7(4): 355-358

Selected conference papers

- August 2014 – presenter and expert panelist at International Conference on End of Life, Queensland University of Technology, Brisbane
- August 2013 – invited presenter at Annual Scientific Meeting of the Human Genetics, Queenstown.
- July 2012 – presenter at 15th International Philosophy & Psychiatry conference, University of Otago.
- June 2012 – presenter at International Association of Bioethics conference, Rotterdam, Netherlands.
- January 2012 – keynote speaker at New Zealand Bioethics Conference, University of Otago.
- July 2011 – invited speaker at Neurolaw in Australia symposium, University of McQuarrie, Sydney.
- March 2011 – organiser of and participant in 'Future of Fairness' conference, University of Otago, 2011.
- May 2010 – invited speaker at 11th Annual Medical Law Conference, Wellington.
- October 2009 - invited speaker at *The future of public participation: cultures, contexts and challenges* conference, Banff, Canada.
- September 2009 - invited discussant at 'Child-rearing in a risk society' conference, Aston University.
- August 2009 – organiser of Personal Identity in Bioethics Symposium, Glasgow.
- December 2008 – presenter at *TILTing Perspectives* conference, University of Tilburg, Netherlands.
- September 2008 – member of organising committee of, and healthcare stream co-ordinator for, Critical Legal Conference, University of Glasgow.
- July 2008 – presenter at World Congress on Health Law, Recife, Brazil.
- November 2007 - co-organiser of, and speaker at, Assisted Dying Symposium, Glasgow.

Conferences and symposiums organised

As Director of the NZLF Centre for Law & Policy in Emerging Technologies, I have organized several activities in the form of public talks and academic symposiums, including:

- October 2013 – One-day workshop on Preventive detention and risk prediction (with John McMillan)
- September 2013 – Public discussion with Julian Savulescu on legal and ethical issues in genetics. (Co-hosted with Genetics Otago and Bioethics Centre)
- September 2012 - Public discussion of Law Commission report on cyber-bullying. Guest speakers: Steven Price and Thomas Beagle
- November 2011 – Neuroethics and law colloquium. Guest speakers: Nicole Vincent (Aus), Francoise Baylis (Can)
- July 2011 – Talk and discussion: '"A new future for humanity?" Can human enhancement go too far?' Guest speakers: Nick Agar (Victoria University) and Russell Blackford (Aus)
- March 2011 – Future of Fairness; 2-day international conference, including evening of public talks. Keynote speakers: Prof Andy Miah (UK) and Prof Ronald Green (USA)
- March 2011 – Talk and discussion: 'Wikileaks: Guardian of the public interest, or hotbed of anarchy?' Guest speakers: Prof Andy Miah (UK) and Jeff Matsuura (USA)
- August 2010 – Workshop: 'De minimis curat lex? Discussing the regulatory challenge of nanotechnology' Guest speaker: Dr Di Bowman (Aus)

Supervision of Postgraduate Students

PhD

Hui Yun Chan
Supervisors: **Colin Gavaghan,** Nicola Peart and Mark Henaghan
Enrolment date: May 2011
Degree awarded, May 2015

Amir Bastani
Supervisors: **Colin Gavaghan** and Mark Henaghan
Enrolment date: October 2011
Submitted May 2015

Kathryn Tagg
Supervisors: **Neil Pickering** and Colin Gavaghan (40%)

Enrolment date: October 2005 (deferred until 2011)
Expected completion date: June 2015

Jane Adams
Supervisors: **Barbara Brookes** and Colin Gavaghan (30%)
Enrolment date: 2011
Expected completion date: end 2015

LL.M.

Joanne Lee
Enrolment date: April 2011
Completed: July 2012

Masters in Bioethics and Health Law

Completed

- (with Lynley Anderson) Paula McCormick
- (with Grant Gillett) Cait O'Donnell
- (with Grant Gillett) Wendy Muircroft
- (with Gareth Jones) Michelle Byszkow
- (with Mike King) Albany Lucas
- (with Mike King) Harriet McKinnon

My Honours student, Stephen Thomson, was the joint recipient of the Legal Research Foundation Writing Awards (Unpublished Undergraduate Student Paper Award) 2012 for his Honours dissertation.

Other professional activities

- Peer reviewer of book proposals for Wiley-Blackwell, July 2010, January 2011 and October 2012

- Peer reviewer for: Neuroethics (Springer), 2014; Law, Innovation and Technology (Hart Publishing), 2013; New Genetics and Society (Taylor & Francis), 2013; Health, Risk and Society (Taylor & Francis), 2011; Medical Law Review (Oxford University Press), 2010; Bioethics (Wiley-Blackwell), 2008 and 2010; Journal of Medical Ethics (BMJ Publishing Group Ltd), 2009.

- Member of editorial committee of *Law, Innovation and Technology* (Hart Publishing)

- Member of editorial advisory board of *Journal of Professional Negligence* (Bloomsbury Professional)

- Member of advisory group to Genetics Otago.

- Founder member of multi-disciplinary Electronic Media Research Group, Otago University.

Media commentaries and columns on professional matters

- December 2014 – "Is safety just a big disguise, that hides among the other lies?", *Pundit* blog
- October 2013 – interviewed on Radio National 'Nine to Noon', RadioLive and NewsTalkZB
- February – May 2013 – monthly column for D-Scene newspaper
- September 2013 – featured on TVNZ's "7 Sharp" current affairs programme, discussing implications of behavioural genetics for criminal law and sentencing.
- August 2013 - interviewed on Radio National 'Nine to Noon'.
- December 2012 – started the Emerging Technologies Centre blog. This has become a prolific and productive source of engagement with the public, as evidenced by the 93 substantive comments attracted by a single post in March 2013. (https://blogs.otago.ac.nz/etc/)
- August 2012 – 'Dilemmas in medicine'; full page interview in D Scene free newspaper
- May 2012 - 'If you tolerate this, then your granny will be next? Colin Gavaghan on the euthanasia debate in New Zealand', Otago University Bioethics centre blog, http://bioethicscentre.posterous.com/130772764
- December 2011 - featured in Dominion Post column 'Move over, cautionary ones, informed thinking is emerging'
- June 2011 – interviewed in Tone magazine feature, 'The Tomorrow People'. Viewable at http://www.andymiah.net/wp-content/uploads/2011/07/2011.05-ToneMagazine.pdf

---

Selected academic and public talks

- April 2015 – recorded interview on L law at end of life" for Royal Australasian College of Physicians.
- October 2014 - invited speaker at Faculty of Law, University of Ottowa
- July 2014 - invited participant at Personalised Medicine Workshop, UTAS, Hobart
- April 2014 - invited panelist at Judges' Clerks conference, Wellington
- April 2014 - invited speaker at the NZ Association of Scientists *Science & Society* conference, Auckland
- August 2013 – Otago University Winter Lecture series, Wellington and Auckland
- August 2013 – panelist at Genetics Roundtable, Queenstown
- November 2012 – presentation (with Amir Bastani) to Genetics Otago annual symposium.
- September 2012 – guest lecture to University Club, University of Otago
- September 2012 – invited speaker at New Zealand Skeptics conference.
- August 2012 – speaker at Hospice NZ's Public Meeting to Discuss Euthanasia, Wellington (with Maryan Street MP and Baroness Ilora Finlay)

- July 2012 – co-organiser and member of panel at NZ International Science Festival,– Café Sci: Do our genes justify our behavior?
- April 2012 – speaker at Centre for Theology and Public Issues discussion on euthanasia and assisted dying, University of Otago
- June 2011 - lecture on 'Euthanasia and Assisted Suicide' to U3A, Timaru
- May 2011 – speaker at Southern Science Series event, Wanaka
- March 2011 – lecture on 'genetics and law' to U3A, Timaru
- July 2010 - panelist at NZ International Science Festival, Dunedin
- May 2010 - guest lecture at University of Canterbury
- April 2010 - lecture on 'Euthanasia and Assisted Suicide' to U3A, Dunedin

stuff.co.nz

"CG2"

Margaret Page dies in rest home after 16 days

BY KIRAN CHUG, STACEY WOOD AND TIM DONOGHUE Last updated 05:00 31/03/2010

Margaret Page became the face of a debate which drew euthanasia supporters, legal experts and the Catholic Church to speak out on her decision to starve herself to death.

Last night, 16 days after she stopped eating, the 60-year-old woman died at a Wellington rest home.

It was the end of a life which was transformed in one day by a brain haemorrhage.

A police car was last night parked outside the St John of God rest home where Mrs Page had starved herself to death.

Senior Sergeant Paul Wiszniewski said police were alerted to her death at 7.12pm by rest-home staff.

"It appeared to be the people from the care home themselves."

The Dominion Post revealed last week that Mrs Page had stopped eating and refused attempts by health authorities to make her more comfortable.

Her stance sparked legal and ethical debate, and, while her family had supported her decision, her husband, Barry Page, had wanted her to be forced to eat.

Mrs Page had crammed her life with karate, scuba diving, kayaking and sporting activity before suffering a brain haemorrhage while kayaking down the Otaki River in 1991.

Since then her speech and movement had been severely limited, and she moved into the St John of God home in Karori in 2001.

Her condition deteriorated, from one of being capable of walking short distances to needing help to eat and shower.

St John of God Haurora Trust chief executive Ralph La Salle said staff and residents were deeply saddened by Mrs Page's death.

"Our thoughts and prayers are with Mrs Page and her family and have been throughout the past weeks - a time which has been exceptionally difficult and emotional for Mrs Page, her family, other residents, staff and everyone who knew her," he said.

"We continued to provide a very high level of care for Mrs Page until her death. We worked closely with her GP, who visited daily, the Ministry of Health and staff from the Mary Potter Hospice, who also provided care to Mrs Page."

Mr La Salle said that food and water had been offered to Mrs Page by staff members whenever they went into her room and at regular intervals. In addition, a staff member was dedicated to Mrs Page's care during the last period of her life.

"Mrs Page maintained her resolve to refuse food until the very end of her life," he said.

Voluntary euthanasia activist and Dignity New Zealand founder Lesley Martin said it was sad that Mrs Page had had to starve herself to achieve the end she wanted.

"I'm pleased she had the strong degree of support that she did, but I'm sad that this is the best we can offer people in her situation."

Mr Page, who looked after his wife for 16 years, told The Dominion Post last week that Mrs Page was determined to end her life.

Legal experts had said the law was on Mrs Page's side as she had been lucid. However, suicide experts cautioned that assessing suicidal patients was difficult.

Capital & Coast District Health Board staff visited Mrs Page after her hunger strike was revealed.

Mr Wiszniewski said police were at the care home last night and Mrs Page's death would be referred to the coroner.

- with NZPA

- The Dominion Post

This is the annexure marked **"CG2"** referred to in the affidavit of **Colin James Gavaghan** affirmed at Dunedin this 15th day of May 2015 before me

Signature ....

A Solicitor of The High Court of New Zealand / A Justice of the Peace

A.R. Day
4240
DUNEDIN
Justice of the Peace for New Zealand