

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 UDO SCHUKLENK
AFFIRMED 16 MAY 2015

RUSSELL MEVEAGH

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I, UDO SCHUKLENK, of Kingston, Ontario, Canada, Professor, affirm:

Introduction

1. I am a Professor of Philosophy in the Department of Philosophy at Queens University in Canada. I currently hold the Ontario Research Chair in Bioethics.
2. I have previously affirmed an affidavit in this proceeding, dated [x] April 2015 ("**April Affidavit**"), which is to be filed at the same time as this affidavit. In the April Affidavit I set out my qualifications and the current positions I hold. I have read the Code of Conduct for Expert Witnesses and agree to comply with it.
3. I have read the affidavits of:
 - (a) Baroness Ilora Finlay, dated 6 May 2015 ("**Finlay Affidavit**");
 - (b) Dr Harvey Chochinov, undated ("**Chochinov Affidavit**"); and
 - (c) Dr John Kleinsman, undated ("**Kleinsman Affidavit**").
4. The purpose of this affidavit is to provide evidence in reply to a number of points made by Baroness Finlay, Dr Chochinov and Dr Kleinsman.

Executive summary

5. The key points that I make below in relation to the Finlay Affidavit, Chochinov Affidavit and Kleinsman Affidavit are:
 - (a) palliative care cannot alleviate all suffering to the satisfaction of all patients;
 - (b) claims of coercion and vulnerability are unsubstantiated;
 - (c) the distinction between actively administered aid in dying and prescription of a drug is a false one; and
 - (d) in some places, data is misused or does not support the proposition for which it is advanced.

Response to the Finlay Affidavit

6. At [7], Baroness Finlay concedes that even with current advances in palliative care medicine, palliative care will not be able to relieve all the suffering that catastrophically ill patients might encounter. Accordingly, any policy devised in this context must take into account the suffering that is inevitably felt by some individuals in palliative care.
7. At [11], Baroness Finlay attempts to draw a distinction between FAID and AAID in terms of the relationship between the patient and the doctor, and the level of activity or passivity of the patient. However:
 - (a) In both cases the patient must actively agree to the course of treatment, and thereby actively exercise her autonomy. The mere bodily movement makes no difference, ethically.



- (b) The distinction is only important in some moral frameworks, especially religious ones. Many secular ethicists argue that this distinction belabours a moot point. In their view, the only question that matters is whether death is in the patient's best interest. If it is, it is a moot point whether that best interest is served by actively administering, on a patient's voluntary, competent request, a drug, or by prescribing a drug that the patients take themselves.¹
8. At [12], Baroness Finlay compares the drugs used in assisted dying to those used in judicial executions in the United States. The paper cited argues that the method of lethal injection is flawed. However, the problems flagged by the authors of this paper, being the absence of proper training of those administering the lethal drugs, and the remote administration of drugs, do not map on the assisted dying situation.
9. At [19], Baroness Finlay relies on the Oregon Public Health Division ("OPHD") report tables. However, the table in the report provides no information regarding the circumstances of the outlier cases. The table alone provides insufficient information to allow inferences to be drawn.
10. At [20], Baroness Finlay suggests that 40% of Oregon patients accessing FAID cited "being a burden" among the end of life concerns behind their request for PAS. However, this does not provide evidence for any claim of coercion. By way of comparison with the 40% figure, more than 90% were concerned about their loss of autonomy, and 86.7% were concerned about their inability to engage in activities that made their lives worthwhile to them.² The sample size is not sufficiently large to demonstrate that this is an issue featuring realistically high on the agenda of people asking for FAID in Oregon. Even if it did, the fact that patients mention it does not show that it had any coercive force in their decision-making.
11. At [21] - [22], Baroness Finlay sets out personal anecdotes which do not provide meaningful evidence.
12. At [23], Baroness Finlay refers to elder abuse. The data we have so far on the kind of patients who request assisted dying do not support these somewhat vague references to elder abuse. If anything, the average patient requesting assisted dying is a well-educated, financially secure elderly patient with late-stage cancer.³ The proposition that elder abuse would be an issue if assisted dying was decriminalised is not supported by the data from jurisdictions that have decriminalised assisted dying.
13. At [24] - [26], Baroness Finlay states that a doctor's attitude has an important effect on a patient's thought process. She is correct that framing can affect patient decision-making. However, the patient profile of those asking for assistance in dying in European jurisdictions does not suggest that these patients were a victim of framing effects; they were well-educated patients dying mostly of late-stage cancer.⁴ I also note that

¹ Discussed in Schuklenk U et al Report of the Royal Society of Canada Expert Panel: End-of-Life Decision Making (2011) at 3.6.a.

² OPHD, 'Oregon's Death with Dignity Act 2014', Table 1

³ N Steck, M Egger, M Maessen, T Reisch, M Zwahlen (2013). Euthanasia and assisted suicide in selected European countries and US states: systematic literature review. Med Care 51(10): 938-944.

⁴ OPHD, 'Oregon's Death with Dignity Act 2014', Table 1



the paper that Baroness Finlay cites in support of this point talks about the ways in which doctors make errors in prescribing treatment, and the psychological factors that explain this. It does not address the effect of the doctor's attitude on the patient's thought process.

14. At [26], Baroness Finlay appears to assume that those patients who request assisted dying do so because they do not receive the full range of preferred treatment. The article cited provides no evidence to back up this claim.
15. At [29], Baroness Finlay annexes a paper that she and Professor Robert George wrote critiquing a paper by Battin and others. The data relied on in that study provides no information on patients' "emotional states" and "personality types". Accordingly, no conclusion can be drawn from that study in relation to Oregon.
16. At [30], Baroness Finlay conflates correlation with causation. She states that over sixty-fives accounted for more than two thirds of those who died by ingesting legally supplied lethal drugs. I note that 97% of those who died by ingesting legally supplied lethal drugs patients were also white, 98% had health insurance, over 90% were enrolled in a hospice, and 72% were college educated. Further, the House of Lords Report that Baroness Finlay refers to frequently indicates that between 70 and 80% of elderly people in the UK support the decriminalisation of assisted dying.
17. At [31] - [32], Baroness Finlay appears to suggest that clinically depressed people are vulnerable and that they are per se incompetent. None of the literature that she cites supports the claim that clinical depression equates to incompetence to make one's own decisions. Furthermore, it is unclear to what extent depression motivates requests for assisted dying.⁵
18. At [32], it is worth noting that the study that Baroness Finlay cites in support of her claim examined a mere 58 patients. 18 of these patients successfully obtained a prescription for lethal drugs and, of these 18, 3 met the criteria for depression. Accordingly, Baroness Finlay is incorrect in stating that one third of these 18 patients had depression; the correct figure is 16.7%. Regardless of this, the sample size of this survey is too small to permit conclusions of the kind Baroness Finlay suggests.
19. In relation to [34], I note that the expert witness cited by Baroness Finlay as stating that 30% of his ALS patients are cognitively impaired specifically does not claim that these patients are necessarily incompetent to make end-of-life decisions with regard to assisted dying.⁶ In fact, he says that sometimes people with these impairments can perfectly understand the nature and implications of their decisions. He suggested that a multi-disciplinary team of experts assessing patient competence would be needed in such circumstances.
20. At [35], Baroness Finlay suggests that doctors are not the professionals best equipped to detect cognitive impairment. However, in Canada

⁵ AJ Bharucha, RA Pearlman, AL Back, JR Gordon, H Starks, & C Hsu (2003). "The pursuit of physician-assisted suicide: Role of psychiatric factors" *Journal of Palliative Medicine*, 6, 873-883.

⁶ House of Lords Report 86-II para 125.

doctors have been involved for many years in discussing with their patients treatment modalities that might be life-shortening. Further, many doctors have long since recognised that it is not always in a patient's best interest to continue living, especially against their declared, informed, competent choices.

21. At [38] - [40], Baroness Finlay compares attempted suicides in palliative care with PAD in the Netherlands. This is not a useful comparison. It is unsurprising that more people will avail themselves of assisted dying when it is available; Baroness Finlay ignores the argument that patients in the Netherlands are better off for having this option.
22. In relation to [40], Baroness Finlay's comparison of large-scale national data from the Netherlands with her limited scope survey is not methodologically sound.
23. At [41], Baroness Finlay notes that 11% of cancer patients expressing a desire for death showed instability in their expressed desire. However, the sample size in the study to which Baroness Finlay refers was 17 terminally ill patients. That is so small a sample as to render the percentage figure entirely moot. In the study referred to, the author of the paper concludes that patients who expressed a clear desire for assisted death, and who had access to palliative care services, retained a stable desire for physician assisted death over time; palliative care measures did not diminish patients' consistent desire for assisted dying. The issue of instability of desire can be addressed through having a sufficiently long window of time during which a patient's wish to die is shown to be stable. In Oregon the average time that passed between a patient's first request and their death is 47 days, for all patients who died from ingesting lethal drugs prescribed to them under the Act, in the period 1998-2014.⁷
24. At [42], Baroness Finlay states that rational suicide is a disputed term as it cuts across a physician's duty of care. However, conceptually rational suicide is unrelated to the question of a doctor's professional responsibilities.
25. At [44], Baroness Finlay states that Oregon has shown an increase in suicides since 2000. However, Oregon has had consistently higher than average suicide rates when compared to the United States average ever since it reported on this issue in the 1980s. A significant decrease occurred in the 1990s only to reverse again around 2000. Incidentally, the same pattern is repeated throughout the United States.⁸
26. At [45], Baroness Finlay states that the Netherlands suicide rate is higher than that of the United Kingdom. However, this is incorrect. The suicide rate in 2012 in the United Kingdom was 11.6 suicides per 100,000; in Netherlands, the suicide rate in 2012 was 10.5 per 100,000.⁹ However, I

⁷ Oregon Public Health Division, 'Oregon's Death with Dignity Act 2014', Table 1.

⁸ See Figure 1 (<http://www.oregon.gov/oha/amh/CSAC%20Meeting%20Schedule/Suicide-in-Oregon-report.pdf> at 6). Figure 5 does not support the proposition that the higher suicide rates are linked to the introduction of assisted suicide legislation in Oregon (<http://www.oregon.gov/oha/amh/CSAC%20Meeting%20Schedule/Suicide-in-Oregon-report.pdf> at 14).

⁹ In relation to the United Kingdom, see <http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2012/stb-uk-suicides-2012.html>. In relation to the Netherlands, see http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLnl&PA=7052_95&LA=nl

also note that correlation should not be confused with causation. In Germany, for example, where assisted dying is not available, the suicide rate is higher than in either the UK or the Netherlands, as it is in Sweden, Denmark and Finland. There is no connection between decriminalising assisted dying and suicide rates in an entire population.

27. At [46], Baroness Finlay suggests that the prohibition of PAD provides a "bright line". However, clear PAD criteria could also provide a bright line. Further, the claim that people with disabilities would be at heightened risk of abuse has been put forward repeatedly by opponents of assisted dying (and some, but by no means a majority of disability right activists). It is worth noting that they fail to provide data from any of the jurisdictions that have decriminalised assisted dying to support their case. The reason for this is a lack of actual evidence capable of supporting this contention.
28. In relation to [47], OECD data show that the suicide rate in the Netherlands has gone down 4% between 1995 and 2010. The highest increase in the same period in the EU occurred in Malta, Iceland, Portugal and Poland, none of which have decriminalised assisted dying.¹⁰ Similarly in the United States, in 2013 Alaska, Utah and Wyoming among others had higher suicide rates than Oregon, despite the decriminalisation of assisted dying in Oregon and not in those mentioned states.¹¹
29. At [48] - [49], no evidence is provided for the existence of the Werther effect in jurisdictions that have decriminalised assisted dying.
30. At [50], Baroness Finlay suggests that Dutch doctors find that euthanasia becomes easier as it is repeated. This concern assumes that doctors providing assisted dying ought to be troubled by it. It is a *petitio principii*. That PAD is problematic and that doctors ought to be troubled by it is assumed to be true, rather than demonstrated, then it is lamented. Even if the administration of lethal drugs became easier for doctors over time, it does not follow that they would take related decisions lightly, as Baroness Finlay seems to imply.
31. In relation to [51] - [53], [55], I note that it is not surprising that a new service that is provided by a health care system would experience an increasing number of users over time. The increase in numbers does not constitute evidence of an abusive system.
32. At [54], Baroness Finlay speculates that the decline in referrals for psychiatrist assessment in Oregon is unlikely to have occurred because general physicians have become better at assessing capacity, without producing any evidence. She further speculates that it is due either to "doctor shopping" or assisted dying becoming routine, again without providing any evidence.
33. At [57] - [58], Baroness Finlay extrapolates from Oregon's current death rate from FAID to an estimated death rate from PAS if it was adopted in England and Wales. However the death rate that would arise in England

¹⁰ See <http://www.oecd-ilibrary.org/sites/9789264183896-en/01/07/index.html?jsessionid=3vojs298mva0l.x-oecd-live-02?contentType=&itemId=%2Fcontent%2Fchapter%2F9789264183896-10-en&mimeType=%E2%80%A6&csp=be14f43f3ab04271fc917d221d83f55>

¹¹ See www.afsp.org/understanding-suicide/facts-and-figures.

and Wales cannot be inferred simply from Oregon data. There are a number of factors that would affect uptake. However, Baroness Finlay's claim that there would be a significant uptake if FAID was decriminalised also points to a demonstrable need for FAID.

34. At [59], Baroness Finlay incorrectly attributes an implicit value judgment to the legalisation of AID. I suggest that the value judgment displayed here is one of respect for the autonomous choices of people who consider their lives not worth living in their best considered judgment, based on the best information available at the time of decision-making.
35. At [61] - [62], Baroness Finlay suggests that the majority of doctors oppose assisted dying. However, I note that doctors' views on this issue are evolving, just as societal views have shifted dramatically over the last decade or so. The Canadian Medical Association has recently shifted its stance on the subject and ended its opposition to assisted dying, leaving it to its members to make up their minds individually. Significantly, the Canadian Medical Association now describes the provision of assisted dying by doctors as a "therapeutic service".¹²
36. At [63] - [68], Baroness Finlay essentially declares doctors' professional judgment of what constitutes intolerable suffering to be subjective and accordingly insufficient to justify assisting a patient in dying. I note that assessments of patients' claims of 'unbearable suffering' are routinely undertaken today in a number of jurisdictions.
37. At [68], Baroness Finlay again implies that people suffering from depression are unable to make competent choices, which is not the case. I dealt with this above in relation to paragraphs [31] - [32].
38. At [70], Baroness Finlay suggests that no safeguards can be sufficient to allow physician assisted suicide. I suggest that a system can be developed that minimises the risk of abuse and misuse, and that the risks of such a system should be assessed against the benefits to patients. In addition, I note that Baroness Finlay does not anywhere apply the same concern in respect of these end of life decisions that she appears to regard as legitimate, such as decisions to withdraw certain treatments. When the outcome is the same — death — why in one case are safeguards that are less than 100% effective not acceptable (assisted dying) but in the second case acceptable (withdrawing medical treatments).
39. At [73], Baroness Finlay suggests that relational autonomy requires the individual's rights to be balanced against the community's rights. Even if one accepted that relational autonomy should matter in this context, it is far from clear that intolerably suffering patients would have an obligation to continue living for the sake of others who might be distressed by their lives' ending. Further, Baroness Finlay fails to show that decriminalisation would detrimentally affect relational autonomy. She also fails to justify why her argument from relational autonomy does not equally apply to the case of someone who deliberately starves themselves to death or requests the withdrawal of medical treatment.

¹² See <http://www.cbc.ca/news/health/doctor-assisted-suicide-a-therapeutic-service-says-canadian-medical-association-1.2947779>.

40. At [82], Baroness Finlay claims here that the quality of palliative care deteriorated in Oregon. However, in 2015 the *Journal of Medical Ethics* published a survey aimed at addressing the question of whether the decriminalisation of assisted dying impacted negatively on the provision of palliative care in the Benelux countries. It concluded, "The hypothesis that legal regulation of physician-assisted dying slows development of [palliative care] is not supported by the Benelux experience. On the contrary, regulation appears to have promoted the expansion of [palliative care]."¹³ Ultimately, there is no evidence to support the claim that the provision and quality of palliative care has been undermined by legalisation in jurisdictions that have decriminalised assisted dying. Undoubtedly, palliative care remains imperfect in all jurisdictions, despite ongoing developments. It is implausible to argue that assisted dying ought not to be decriminalised until an ideal state of palliative care provision has been reached.¹⁴ Any jurisdiction that considers the decriminalisation of assisted dying should also consider how it can monitor and improve on its provision of palliative care.
41. At [86] - [87], Baroness Finlay continues to assert that the death of the patient is always bad. However, if death is in the best interests of a competent patient who chooses it, it becomes ethically meaningless to draw a distinction between a death that was caused foreseeably by the cessation of treatment or by a treatment decision involving the provision of assisted dying.
42. At [90] - [92], Baroness Finlay does not provide evidence for her assertion that doctors may provide superficial assessments or concur with existing opinions rather than exercising their professional judgment.
43. At [93], Baroness Finlay addresses cooling off periods and coercion, but does not advance any evidence that coercion exists in jurisdictions that have accepted physician assisted death.

Response to the Chochinov Affidavit

44. At [12] - [26], Dr Chochinov sets out how terminally ill people understand dignity. However, the key question in this proceeding is what their views are on assisted dying. Chochinov's research demonstrates unequivocally that they are in favour of decriminalisation of assisted dying.
45. At [25], Dr Chochinov accepts that interventions can help to safeguard a patient's sense of dignity, but does not go so far as to say that they *will*. Loss of dignity cannot be addressed in all cases.
46. At [29], Dr Chochinov states that there is a significant association between sense of dignity and pain. Although this is accurate, other factors also feature prominently in a patient's assessment of dignity and their desire for assisted dying. I addressed this above in relation to paragraph [20] of the Finlay Affidavit.
47. At [30], Dr Chochinov relies on a survey which has a sample size of only 6, which is so small as to be meaningless.

¹³ K Chambaere and JL Bernheim (2015) "Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience" *Journal of medical ethics* doi:10.1136/medethics-2014-102116.

¹⁴ J Barutta and J Vollmann (2015) "Physician-assisted death with limited access to palliative care" *Journal of medical ethics* doi:10.1136/medethics-2013-101953.



48. At [33] - [44], Dr Chochinov addresses the importance of good quality palliative care. However, he does not address the point that for some individuals, nothing can be done to address fractured dignity. At [43], he does recognise that "studies demonstrate that, for some patients approaching end of life, opportunities to find meaning, purpose, address unfinished business and to provide guidance and comfort for soon-to-be-bereft loved ones *can* mitigate distress and enhance sense of dignity". [emphasis added] Further, at [46] and [52], he accepts that not all patients will be served in a satisfactory manner by palliative care.
49. At [51] and at [58], Dr Chochinov accepts that in some cases managing physical distress may involve having to sacrifice conscious awareness. This makes clear that at some point some patients may be required to choose between suffering and palliative sedation. Dr Chochinov's own published research confirms that for some patients neither option is considered satisfactory.
50. At [56.2], Dr Chochinov suggests that the data is not convincing that any safeguards can properly protect patients' interests. However, he does not advance any evidence in support of that proposition.
51. In relation to [56.3], see my comments above in relation to paragraphs [63] - [68] of the Finlay Affidavit.
52. At [56.4], Dr Chochinov cites a study that is over 20 years old (and which predated the Death with Dignity Act) in relation to doctors' willingness to provide assisted suicide. However, I note my comments below in relation to paragraphs [91] - [92] of the Kleinsman affidavit.
53. At [65], Dr Chochinov comments on the quality and availability of palliative care potentially being undermined by the availability of aid in dying. I addressed this above in relation to my comments on paragraph [82] of the Finlay Affidavit.
54. At [68], Dr Chochinov addresses the suicide rate in Oregon. I addressed this above in relation to my comments on paragraph [47] of the Finlay Affidavit.
55. In relation to [117], I note that regardless of whether assisted dying is available, palliative care will be imperfect. Accordingly, the absence of assisted dying will make bad situations worse for those who are subjected to suboptimal palliative care. Of course, none of this means that we should not strive to improve palliative care. I addressed this above in relation to paragraphs [33] - [44] of the Chochinov Affidavit.

Response to Kleinsman Affidavit

56. At [31] - [32], Dr Kleinsman states that terms do not represent common usage, and are euphemistic or vague. I note that the terms "assisted suicide" and "euthanasia" are no more precise than "facilitated aid in dying" and "administered aid in dying". For example, at [36], what Dr Kleinsman refers to as "euthanasia" could more accurately be described as "voluntary euthanasia".
57. At [38], Dr Kleinsman refers to "the ethicists Boudreau and Somerville". However, neither Boudreau nor Somerville is a trained ethicist. Boudreau



is a clinician and Somerville is a lawyer and a pharmacist. Their technical expertise in their respective disciplines does not entail special moral insight.

58. At [40] - [42], Dr Kleinsman relies on the supposed ethical difference between death brought about by an act or omission. However, this difference relies on the assumption that death is bad for a patient, which Dr Kleinsman, like Dr Chochinov and Baroness Finlay, asserts but does not prove.
59. At [55], Dr Kleinsman comments that the impulse towards suicide is often ambivalent, sporadic and influenced by mental illness. I addressed this above in relation to paragraphs [31] - [32], and [41] of the Finlay affidavit.
60. At [56], Dr Kleinsman relies on the opinion of Canadian Physician René A Leiva that freedom of choice about euthanasia is an illusion. However, what is crucial is not whether a decision is absolutely freely made but whether the decision is substantially free, and not the result of coercive influences.
61. At [60], Dr Kleinsman suggests that assisted dying is merely a claim for access to a privileged means of suicide. The reason for the involvement of medical professionals in assisted dying is due to the desire to protect the safety and security of the person, and the high levels of regulation around the actions of medical professionals.
62. At [63] - [76], Dr Kleinsman sets out "clashing narratives". However, those who do not agree with assisted dying would not be required to avail themselves of it.
63. At [89], Dr Kleinsman relies on the Hippocratic Oath. This oath has limited value in the modern world. I note for example that it also prohibits doctors from practising surgery. Today the Hippocratic Oath is not used in graduation ceremonies of very many medical schools the world all over today. As of 2002, only one of 12 medical schools in Australia and New Zealand was using a modified version of the Hippocratic Oath in its graduation ceremonies.¹⁵
64. At [91] - [92], Dr Kleinsman states that a law change would be a break from long-standing societal views in New Zealand. I cannot comment as to whether what Ms Seales' case will do is bring about a law change; I understand that to be a matter in dispute. However, what I can say is that even if it is true doctors and societies adapt and change. In Canada, following *Carter*, the Canadian Medical Association has begun to refer to assisted dying as a therapeutic service.¹⁶
65. In relation to [99], I note that competence, and whether a patient's quality of life has reduced to the level that it is unbearable, have been shown by

¹⁵ PM McNeill, SB Downton. 2002. Declaration made by graduating medical students in Australia and New Zealand. *Medical Journal of Australia* 176(3): 123-125.

¹⁶ The President of the Canadian Medical Association, in his capacity of President of the Canadian Medical Association stated, 'What we want to do is really make sure patients who are eligible under the new rules have access to this therapeutic service, but at the same time we need to be very careful that physicians have the right to conscientious objection for moral or ethical reasons or religious reasons.' (<http://www.cbc.ca/news/health/doctor-assisted-suicide-a-therapeutic-service-says-canadian-medical-association-1.2947779>)

the Dutch to be standards that medical specialists are able to evaluate in a satisfactory manner.¹⁷

66. In relation to [107], as I set out above in relation to paragraph [46] of the Finlay Affidavit, not all disability activists are opposed to assisted dying. Often disabled people are the ones petitioning for voluntary euthanasia legislation, precisely because of their inability to access assisted dying otherwise.
67. At [110], Dr Kleinsman suggests that legalising assisted suicide or euthanasia is contrary to the state's responsibility to protect its citizens. However, protection of autonomous choice is an important plank of the state's responsibility towards citizens.
68. At [115], Dr Kleinsman discusses vulnerability. Although he correctly assesses individuals who may be vulnerable in society, this does not map onto an argument around assisted dying. The individuals who consistently have the highest uptake of assisted dying are those who are proportionately wealthier, better educated and are not people of colour. Assisted dying does not disproportionately affect the poor or the disabled. I discussed this above in relation to paragraph [30] of the Finlay affidavit.
69. At [132], Dr Kleinsman suggests that assisted dying creates additional pathways for elder abuse and neglect. However, there is no evidence from jurisdictions that have decriminalised assisted dying that elderly individuals not suffering from terminal illness are disproportionately affected by assisted dying.
70. At [165], Dr Kleinsman states that regulatory controls cannot be enough to mitigate or eliminate many of the risks posed by assisted dying. I addressed this argument above in relation to paragraph [70] of the Finlay Affidavit.
71. At [182] - [192], Dr Kleinsman discusses the Oregon experience. I have addressed this above in relation to the Finlay Affidavit.

AFFIRMED at Kingston, Ontario, Canada
this 16th day of May 2015 before me:

RICARDO SMALLING
Barrister and Solicitor LSUC #62639T

A person duly authorised to administer oaths in
Ontario, Canada

Udo Schuklenk

¹⁷ KD Ruijs, BD Onwuteaka-Philipsen, G van der Wal, AJ Kerkhof. 2009. Unbearability of suffering at the end of life: the development of a new measuring device, the SOS-V. BMC Palliat Care 3;8:16 doi: 10.1186/1472-684X-8-16