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 IN REPLY OF ERIC JON KRESS
SWORN MAY 2015

RUSSELL McVEAGH

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I, **Eric Jon Kress**, medical doctor of Missoula, Montana swear:

Introduction

1. I am a medical doctor, qualified from the University of Washington in 1984 and completing my residency in family medicine between 1984 and 1987.

2. I have been certified by the American Board of Family Practice since 1987 and I hold a certificate of Added Qualifications in Hospice and Palliative Medicine. I am an Awarded Fellow of the American Academy of Family Practice and a member of the American Academy of Family Medicine. I was awarded a fellowship in the American Academy of Family Practice in 1994. I am a member of the Montana Academy of Family Medicine and served as president of the Montana Academy of Family Practice in 1993. I have served on the Montana Medical Associated Board of Directors for several years, and currently serve on the Board of Trustees. I am president of the Western Montana Medical Society and a member of the American Medical Association. I have served as medical director at the Hospice of Missoula for 9 years. A copy of my CV is attached as "**EJK-1**".

3. I have been asked to provide this affidavit in response to the evidence filed on behalf of the Crown in this proceeding.

4. Prior to *Baxter v Montana,* I had no involvement in aid in dying policy or advocacy. In 2014, Montana declined to pass a Bill that would criminalise providing aid in dying. I testified at the judiciary committee in that case opposing the bill. I also testified at trial in New Mexico in a case seeking to establish the right of a terminally ill patient to choose aid in dying, *Morris v Brandenberg*. My decision to become involved in those matters was a consequence of my experience that demonstrated to me that aid in dying is a valuable option for some patients.

5. I have read the High Court Code of Conduct for Expert Witnesses, and I agree to comply with that Code.

My experience with aid in dying

6. As medical director of a hospice, I see our goal as providing a way for helping people to live better when they are dying from a terminal condition; not so much to help them die, but to help them live well while they are still alive.

7. For most of my 28 years in practice, aid in dying has not been provided in Montana. Following the 2009 decision of the Montana Supreme Court in *Baxter v Montana*, which held that physicians who provide aid in dying to their patients are not subject to criminal prosecution, doctors in this state began to provide those services.

8. In Montana, hospices continue to provide services to patients utilising aid in dying. Hospices still aim to support people through the dying process as they always have. In my experience, hospices continue to provide that care and still focus on that primary treatment objective.

9. Since the ruling, I have continued to provide advice to patients in their end of life circumstances. As was the case before *Baxter*, quality

hospice care is all that is needed in most cases to help terminally ill patients through their dying process. Some patients, however, face a hard death, regardless of palliative care, and wish to have more control over the timing and manner of their passing.

10. Since *Baxter*, I have provided medical advice to many terminal patients. I have been requested to provide aid in dying services to approximately 30 patients. Those patients come to me in two main ways. Some are already enrolled in the hospice where I practice and so are receiving palliative care, while others are patients from my family practice.

11. Witnesses for the Crown have suggested that aid in dying fundamentally changes the nature of the service provided by the medical profession. In my experience there is a change, but it is a positive one. I have not experienced patients who are worried that they will be subject to pressure from doctors, and have not seen any increase in reluctance to take up referrals to hospices. However, for those patients who are concerned about controlling their circumstances, the possibility of aid in dying is a relief.

12. My experience in Montana accords with the predictions of continuity of palliative care made by Simon Allan in his affidavit at paragraph [26]: in my experience the hospice movement has continued as before. In Montana, some doctors provide aid in dying services and some (probably the majority) do not. I would think that the majority of doctors would not want to go through the process necessary to feel comfortable that they were complying with the law and had a good understanding of how best to provide aid in dying. Others will object for moral reasons, as is the case in other areas of healthcare. There has been no suggestion here that doctors must provide aid in dying services.

13. My process when somebody raises this with me is to tell them straightaway that I will not be able to prescribe lethal medicine immediately. It would be necessary for me to review their file, contact specialists as required, and confirm that the patient's condition is terminal. It is also important for me to make sure that I know the patient and understand the patient, and have been able to address whether there are any other underlying factors, such as poorly controlled pain, that can be ameliorated. I try to ensure that patients who are considering aid in dying are receiving hospice care because that ensures that they will get the palliative care they need.

14. Suggestions from Baroness Finlay that some doctors practising in a jurisdiction that permits aid in dying will "view the death of the patient as a solution to the problem they present" (at paragraph [61]) as a matter of routine (paragraphs [50]-[54]) is, frankly, surprising from someone involved in our profession. I can assure the Court that my concern to ameliorate suffering has not changed.

15. Soon after the *Baxter* decision, one of my patients who was dying of amyotrophic lateral sclerosis (ALS) asked me for aid in dying. He was a wealthy self-made man who had been incredibly active both in his professional and personal life. However, because the decision was new, I was reluctant to write a prescription and ultimately did not do so. This was the first time that I had had to consider the position and I was not comfortable providing a prescription at that point. I felt I needed to do more due diligence to understand the process. That patient died through his own efforts approximately three or four weeks after I had

refused to provide the prescription. From what we could tell, he killed himself by stockpiling his medications and then putting them down his tube feeder.

16. A second patient came to me through the hospice and was dying of esophageal cancer. From the time he made that request to the point when I felt confident enough to write the prescription, I had met with him on at least three separate occasions over a period of six weeks, and had thoroughly reviewed his medical circumstances. He immediately gained great peace of mind. He took the medication approximately three months after the prescription when the pain caused by his growing tumour became unrelenting and was unable to be controlled through the use of narcotics and steroids. I was present when he died. He opened a bottle of Guinness and asked that we all join him in a toast. He told me before he died that if there was anything I could use from his experience to make aid in dying more available, that I please do so.

17. In the six years since the *Baxter* decision, I have written 10 prescriptions for aid in dying. All of those patients were of sound mind, none was depressed and not one of them was "suicidal". They all loved life and told me that they would prefer to live, but not in the miserable conditions that their terminal disease imposed on them.

18. In my view, aid in dying is one compassionate medical treatment option for dying patients, among a number of others that physicians providing care to dying patients can offer. There are other options that provide patients with a measure of control over the timing of their death. Those include removing life prolonging interventions (such as a feeding tube or a ventilator, or deactivating a cardiac device) or providing palliative sedation. Palliative sedation involves intravenously administering medication to induce unconsciousness, so that the patient is unaware of suffering, and withholding nutrition and hydration until death arrives. In some cases, the medication itself can hasten the patient's death.

19. Those options are not considered to be suicide, even when the patient clearly chooses the option in order to cause death. I agree with that position, and also consider that aid in dying is not suicide.

20. Medical doctors are familiar with, and are regularly required to determine, mental competency and the ability to provide informed consent in a variety of circumstances. Those include decision to refuse treatment or to request the withdrawal of treatment or, in some cases, palliative sedation, as well as other fundamental medical decisions. There are standard tests and examinations to help distinguish depression from sadness, for example.

21. There have been efforts in Montana to enact a statutory scheme to govern aid in dying as exists in Oregon, Vermont and Washington. Those efforts have not succeeded. Similarly, opponents of aid in dying have attempted to enact legislation prohibiting the practice, but have not succeeded. Currently, therefore, the practice remains subject to the limits recognised in *Baxter* and to professional practice standards, just like medical decisions around removing life sustaining treatment and terminal sedation.

22. I frequently know the families of my patients and I have seen that family members of a patient who chooses aid in dying are glad that their loved one was able to achieve a peaceful death, at home, surrounded by

loved ones. This was certainly true for the three patients that asked me to be present when they took the medication. The family members of patients that have chosen aid in dying have universally been grateful to me for allowing the patient to have a peaceful death. I am familiar with a study that shows that none of the adverse impacts known to afflict survivors of someone who has committed suicide are experienced by survivors of patients who choose aid in dying.[1] My experience is consistent with the findings in that study.

SWORN at Missoula, Montana this day of May 2015 before me:

Mary K Wheeler

A person duly authorised to administer oaths in Montana

Eric Jon Kress

Eric Jon Kress

MARY K. WHEELER
NOTARY PUBLIC for the
State of Montana
Residing at Lolo, MT
My Commission Expires
March 14, 2016.

[1] Ganzini, L et al *Mental Health Outcomes of Family Members of Oregonians who Request Physician Aid in Dying*, 38 Journal of Pain and Symptom Management 807 (2009).

Eric Jon Kress MD, FAAFP
Missoula,MT 589804

PURPOSE

To communicate my qualifications and work experience as a Family Physician.

EXPERIENCE

Family Physician at Western Montana Clinic in Missoula, MT - 1998 - present

Multi speciality group private practice in Family Medicine

Assistant Medical Director at Recovery Center - Missoula, MT April 2013 to present

Medical Director at Hospice of Missoula - 2003 - December 15th 2011

Medical Director at Saint Patrick's Hospital Addiction Treatment Program - 1999-2001

Family Physician at Family Practice Missoula - 1989-1998

Single group practice in Family Medicine

Resident physician Family Medicine Spokane - 1984-1987

EDUCATION

University of Montana - BA, 1978, Chemistry with High Honors

University of Washington - MD, 1984

University of Washington Affiliated residency in Family Medicine at Family Medicine Spokane - 1984-1987

BOARD CERTIFICATION

American Board of Family Practice (ABFP) - 1987 - present, most recent recertification 2008. On this exam my score ranked at the 94th percentile of all physicians taking the test

Certificate of Added Qualifications in Sports medicine via ABFP, initial 1998, with recertification 2008

Certificate of Added Qualifications in Hospice and Palliative Medicine via ABFP, 2009

Awarded Fellow of the American Academy of Family Practice (FAAFP), 1994

Board Certification in Addition Medicine; January 2015, awarded by the American Board of Addiction Medicine

MARY K. WHEELER
NOTARY PUBLIC for the
State of Montana
Residing at Lolo, MT
My Commission Expires
March 14, 2016.

MARY K. WHEELER NOTARIAL SEAL STATE OF MONTANA

2894754 v2

This is the annexure marked **"EJK-1"** referred to in the affidavit of **Eric Jon Kress** sworn at Missoula, Montana, United States of America this day of May 2015 before me

Signature .....

A person duly authorised to administer oaths by the law of Missoula, Montana, United States of America

Eric Jon Kress

PROFESSIONAL ORGANIZATIONS

American Academy of Family Medicine, 1984-present. Awarded a Fellowship in the American Academy of Family Practice in 1994

Montana Academy of Family Medicine, 1984-present. I served as President of the Montana Academy of Family Practice in 1993

Montana Medical Association, 1987-present. I have served on the Board of Directors for the MMA for several years and currently serve on the Board of Trustees

Western Montana Medical Society, 1987-present. I have served as president of this organization from 2000 to present

American Medical Association, 2010-present

American Society of Addiction Medicine, 2013-present

MEDICAL RELATED ACTIVITIES

Missoula Marathon Medical Director 2007, 2008, 2009, 2010, 2011

Appointed to the faculty of the University of Utah School of Medicine as an Associate Professor in the Department of Family Medicine to train medical students at clerkships in Missoula.

Appointed to the faculty of the University of Washington School of Medicine as an Associate Professor of Family Medicine for teaching residents at the UW affiliated residency, Family Medicine Residency of Western Montana in Missoula, Mt

FAMILY

Spouse: Linda Hom, Interior Designer

Son: Peter, 24 year old student at Montana State University

OUTSIDE INTERESTS

Skiing, cycling, golf, hiking, hunting, fishing