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

SECOND AFFIDAVIT OF MICHAEL ASHBY
AFFIRMED 18 MAY 2015

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I, MICHAEL ASHBY, consultant, of Tasmania, affirm:

Introduction

1. I am a Consultant in Palliative and Pain Medicine practising in Tasmania, and Professor of Palliative Care at the University of Tasmania, Australia.

2. I have affirmed a previous affidavit in these proceedings, which was filed on 24 April 2015. As stated in that affidavit, I have read the Code of Conduct for Expert Witnesses and agree to comply with it.

3. This affidavit replies to certain evidence filed by the defendant. In the light of the condensed timeframe I am unable to reply to all of the points made in the defendant's affidavits that fall within my area of expertise. However, the fact that I have not addressed these points should not be taken as indicating my agreement with them.

Overview of my response to this evidence

4. These affidavits highlight that there is broad agreement between me and the Crown's witnesses to the following extent:

   (a) Palliative care is a holistic, multi-disciplinary care model which attempts to help patients deal with symptoms and pain as well as emotional, social, spiritual and psychological wellbeing (for example, Finlay at paragraph 120).

   (b) Palliative care has made great advances over the last few decades (Roderick MacLeod at paragraph 41).

   (c) While palliative care can attempt to address pain, physical symptoms and psychological and emotional issues, it cannot address all suffering in all situations (Dr Chochinov at paragraphs 46 and 52, Finlay at paragraphs 113 and 119, Allan at paragraph 17). I note that Dr Donnelly alone asserts that palliative care will not allow a "cruel" death and states she had never seen an undignified death. This does not accord with my experience and does not appear consistent with the acceptance in affidavits from other palliative care specialists that palliative care cannot address all suffering in all circumstances.

   (d) Terminal sedation is usually only offered where death is imminent (within days) (O'Brien at paragraph 43.3, Allan at paragraph 19).

   (e) Psychological suffering and emotional issues are the most difficult to address (Finlay at paragraph 120, O'Brien at paragraph 20).

   (f) A small percentage of terminally ill people will make a clear and consistent request for assisted dying notwithstanding the availability of good palliative care (Dr Chochinov at paragraphs 46 and 77.1, Allan at paragraph 44).

   (g) People who persistently request assisted dying tend to be high achievers of independent character (O'Brien paragraphs 26 and 27).

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General objections to the defendant's evidence

5. The arguments against euthanasia generally are well summarised in these affidavits, which have been prepared from some of the world's best known medical anti-euthanasia campaigners.

6. Much of the content of the affidavits is speculative argument that is inherently teleological. I note that there is therefore little evidence provided in support of the assertions made. Importantly, almost none of the content of the affidavits relates to Lecretia and her specific circumstances. So far as I am aware there is no suggestion that any of the following characteristics apply to Lecretia:

   (a) incompetence;

   (b) coercion;

   (c) vulnerability;

   (d) lack of awareness of the options available to her for end of life care; or

   (e) depression.

7. Finally, I note that while it is true that it is impossible to design a system in which every single instance of a medical procedure will be completed perfectly and in compliance with the letter of the policy and procedure that guides it, it is not the case that other procedures, for example open heart surgery, are banned because the operation is on occasion performed with some procedural flaws.

Assessing a patient's capacity / doctrine of consent

8. Many of the defendant's affidavits from palliative care experts discuss the process of assessing competence in patients. The evidence of Dr Harvey Chochinov and Professor Roderick MacLeod questions the ability of physicians to evaluate competency to consent to assisted suicide (Chochinov at paragraph 56.3 and Roderick MacLeod at paragraph 55). They refer to the low level of referrals in Oregon to psychiatrists and the difficulty in determining whether a mental condition is influencing a decision in one consultation. This concern is also touched on by Tony O'Brien (paragraph 33).

9. In my experience, assessment of a patient's competence and non-ambivalence is already part of sound medical practice. Indeed, the doctrine of patient consent is central to medical practice. Consent and capacity are also areas which have been well considered in a legal context (especially in relation to mental health law). Relevant consent decisions can cover a range of medical issues, including decisions that could result in death (for example withdrawal of treatment). Clearly where a patient's decision has serious implications, a high degree of scrutiny is required, but assessment of such competence in relation to such decisions is still very much part of standard medical practice.

10. In my experience, if there is any cause for doubt about a patient's ability to make an end of life decision, additional steps would be taken such as referral to a neuropsychologist or psychiatrist. However, such steps are not necessary in every situation.

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11. From the evidence I have read, there appears to be no question that Lecretia has the capacity to make a decision about assisted dying. She is not suffering from a mental disorder, is not being coerced by others and has maintained her wish to seek assisted dying over a period of time. I have read the affidavit of Lecretia's GP who advises that she would seek assistance as appropriate should any issues arise. This approach seems consistent with appropriate medical practice.

Specific comments on defendant's affidavits

Affidavit of Dr Simon Allan

12. At paragraphs 9 and 10 Dr Allan discusses the transient nature of a desire to die and states that depression is a frequent occurrence in the palliative care context. Neither of those points apply to Lecretia.

13. The same comment applies to Dr Allan's statements regarding fear at paragraphs 12 to 14.

14. I agree with Dr Allan's comment at paragraph 17 that while most symptoms can be well controlled it is not possible to say that all symptoms and pain can be treated if a patient wishes to maintain consciousness and quality of life.

Affidavit of Baroness Finlay

15. Baroness Finlay's affidavit is a long polemic against aid in dying from one of the world's best known anti-euthanasia campaigners. The comments I have made above at paragraphs 5 to 7 (General objections) apply to Baroness Finlay's affidavit. In particular, none of Baroness Finlay's objections to aid in dying appear to apply to Lecretia. They are objections to aid in dying generally.

16. At paragraphs 12 and 13 Baroness Finlay appears to query the efficacy of assisted dying and, in particular, the speed at which lethal drugs take effect. The paradigm of lethal injunctions in prisons seems to be of little relevance to Lecretia's case or even euthanasia more broadly when conducted by qualified health professionals who are not required to remain at a distance from the patient.

17. Paragraphs 15 to 19 of Baroness Finlay's affidavit refer to diagnostic and prognostic accuracy. These points do not appear to apply to Lecretia. Moreover, in my experience, requests for assistance in dying do not arise purely from the knowledge that one is suffering from terminal illness. Rather, they are motivated by the poor quality of life that end of life patients experience and the fear they may experience. Accordingly, the suggestion that people may partake in the option of aid in dying on the sole basis of a mistaken belief that their life will soon end, and in the absence of adverse quality of life or suffering, appears to me, with respect, to be unlikely, and in this case certainly does not apply.

18. I note that Baroness Finlay is aware of three patients who have committed suicide during her years in practice.

19. I have not addressed Baroness Finlay's statements on the implications for society of legalising aid in dying because they are speculative and do not apply to the case that Lecretia brings.

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20. I note Baroness Finlay's comment at paragraph 63 and following that intolerable suffering is a subjective concept. I agree and would add that the same is true of pain and the psychological and emotional symptoms that are experienced by patients at the end of a terminal illness. This makes them no less real, nor less deserving of being addressed to the greatest extent possible, consistent with the wishes and dignity of the individual.

21. I note that Baroness Finlay appears to accept in her discussion of the efficacy of palliative care at paragraphs 74 to 85 that palliative care is not effective at addressing pain and symptoms in all terminally ill patients all the time. That reflects my experience and the experience of other practitioners who have discussed the issue with me.

22. At paragraphs 88 to 94 Baroness Finlay discusses the efficacy of safeguards. I note that many statements contained in this section are assertions, without reference to any empirical data or external sources in support. Much the same can be said for Baroness Finlay's views on the legalisation of aid in dying in the Netherlands and Oregon.

23. At paragraph 119 Baroness Finlay agrees with my evidence that palliative care is unable to relieve all suffering. She and I agree that palliative care has made great advances in recent years. However, it seems unlikely that any such advances will deal with the suffering that Lecretia has outlined in support of her request: namely immobility, total dependence and inability to do what makes life worthwhile. I do not understand her to be asserting that Lecretia should endure such suffering while the world waits for advances in palliative medicine that seem unlikely to address the specfic issues that are relevant here.

24. I agree entirely with Baroness Finlay's view at paragraph 120 that suffering at the end of life is multi-factorial and the purpose of palliative care is to take a holistic approach to addressing these matters. As I noted in my first affidavit, unfortunately in many cases no matter how skilful the palliative care team administering care, there are cases where nothing more can be done to address a patient's suffering to their satisfaction.

Affidavit of Tony O'Brien

25. At paragraphs 19 to 20 under the heading "what percentage of suffering can palliative care currently relieve", Dr O'Brien discusses the nature of suffering. I note that he does not in fact address the question that heads up this section of his affidavit. Dr O'Brien notes that clinicians who are not trained and experienced in addressing the non-medical aspects of suffering may have limited success in addressing them. I confirm that I, and the teams I have worked with in the years I have been a palliative care specialist, have been well trained and have a great deal of experience in addressing the psychological, emotional and spiritual aspects of suffering. Nevertheless, in my experience quality of life and suffering may still remain unacceptable to many patients despite palliative care's best efforts.

26. In Dr O'Brien's classification of patients who request aid in dying, I note his comment that patients in what he describes as Group 3 express a clear and consistent wish to exercise the right to have their life ended at a time and a place and in a manner of their choosing. Typically these patients are not depressed and they do not ordinarily exhibit features of

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other mental illness. On the basis of Lecretia's affidavits, she would appear to fall squarely within this category.

27. Paragraph 30 of Dr O'Brien's affidavit expresses views on public policy issues that are speculative and irrelevant to this case.

28. Dr O'Brien makes specific comments on my affidavit at paragraph 44. Paragraph 44.1 mischaracterises the evidence given at paragraphs 14 to 17 of my first affidavit. Those paragraphs of my affidavit do not say anything at all about the causal relationship between pain and requests for aid in dying. Rather, they address the fact that palliative care may not always completely control a patient's pain.

29. Paragraph 44.2 uses the term "catastrophisation" and refers to Stephen Hawking and Jean-Dominique Bauby as evidence that dependence and impaired mobility are not incompatible with quality of life. The concept of 'catastrophising' has been hitherto more recognised in the field of chronic persistent pain than palliative medicine. Each individual must be free to determine how they will respond to the challenges of dying, and not to have their poor quality of life and suffering judged pejoratively. It is their evaluation of the quality of their life that is important. I also note, out of interest, that Professor Hawking himself publicly supported the UK's Assisted Dying Bill (see an article from *The Gospel Herald* dated 21 July 2014 annexed as exhibit **"MA(2)-1"**).

30. At paragraph 44.3 Dr O'Brien purports to concur with what he says is my view that pain is not a dominant or intractable feature in patients with glial brain tumours. I did not express that view in my first affidavit, nor do I hold it. To the contrary, I agree with the evidence of Rajesh Munglani that Lecretia is at risk of suffering from severe pain as her illness progresses. Moreover, as I said at paragraph 16 of my first affidavit, pain in the head and neck (such as that caused by raised intracranial pressure from an adult glial tumour) can be difficult to control.

Affidavit of Sinead Donnelly

31. At paragraph 21, Dr Donnelly says that in 24 years of practice she has never seen an undignified death. As Chochinov has shown, dignity is a multifactorial and ultimately personal construct, and this blanket assertion cannot surely be made by any practitioner on behalf of so many patients. This certainly does not accord with my own experience, nor the experience of all of the other palliative care experts who have provided evidence for the Crown. Moreover, this appears to conflict with her evidence; at paragraph 27 she acknowledges that intractable pain does occur.

AFFIRMED at Hobart, Tasmania this 18th day of May 2015 before me:

A person duly authorised to administer oaths by the law of Australia

MALCOLM DOUGLAS FARMER
Justice of the Peace
No. 1087

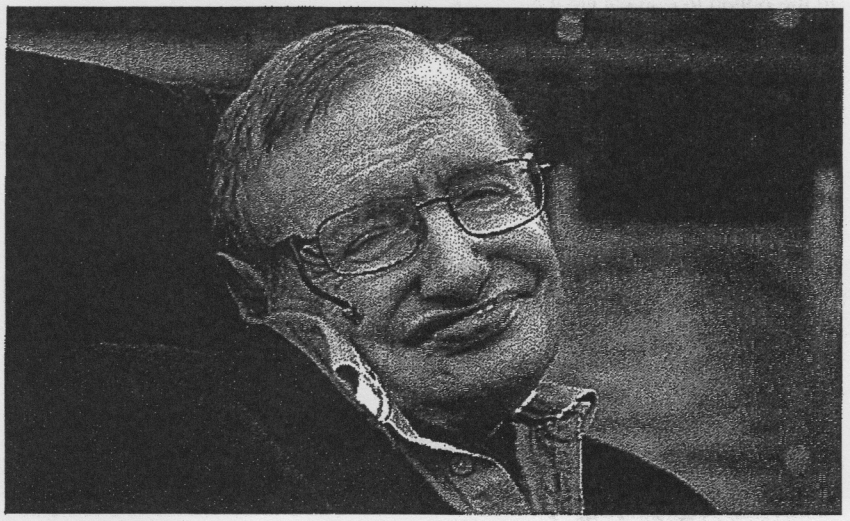
Michael Ashby

Print

Jul 21, 2014 04:35 PM EDT

Stephen Hawking Says He 'Briefly Tried to Commit Suicide,' Supports UK's Euthanasia Bill

By Leah Marieann Klett



Stephen Hawking

Renowned scientist Stephen Hawking recently announced that he "briefly tried to commit suicide" and argued that denying an individual who is suffering the right to commit suicide is "discrimination."

The 72 year old, who is a self-proclaimed atheist, made his comments in response to religious leaders in Britain's assertions that legalizing assisted suicide would be a "grave error" as the House of Lords in Parliament debated the Assisted Dying Bill.

"If you have a terminal illness and you're in great pain, I think you have the right to choose to end your life. We don't let animals suffer, so why should your pain be prolonged against your wishes," the cosmologist said in a BBC interview.

"I think everyone should have the right to choose to end their life whether they are capable of doing so without assistance or not. It is a discrimination against the disabled to deny them the right to kill themselves that able-bodied people have," he continued.

According to BBC, Lord Falconer has led the campaign for the proposed the legislation, which would allow doctors to prescribe a lethal dose to terminally ill patients judged to have less than six months to live.

Making the case for his bill, Lord Falconer insisted that the "final decision must always be made by the patient", with safeguards to prevent "abuse"

Hawking, who is wheelchair bound, agreed, but noted that those considering assisted suicide should be required to show proof from a doctor that they are in great pain, and should also wait two weeks in case they change their mind.

This is the annexure marked "**MA(2)-1**" referred to in the second affidavit of **MICHAEL ASHBY** sworn at Hobart, Tasmania this 18th day of May 2015 before me

Signature .....

MALCOLM DOUGLAS FARMER
Justice of the Peace
No. 1087

A person duly authorised to witness affidavits under the Law of Tasmania

"I think it would be wrong to despair and commit suicide unless one is in great pain, but that is a matter of choice. We should not take away the freedom of the individual to choose to die," said Hawking.

"There has to be safeguards that a person genuinely wants to die and are not being pressurized into it. These safeguards are a matter of discussion. I would suggest as a minimum that two doctors should certify that a person is in pain and has a life expectancy of less than a year. I would also suggest that a person be given two weeks to reconsider her decision to die," he explained.

The scientist also commented that he was given two or three years to live in his early 20s and felt he should have had the option to end his life if he chose to do so.

"That is a decision the individual has to make. It is wrong for the law to take away the option. I admit that when I had my tracheostomy operation, I briefly tried to commit suicide by not breathing. However, the reflex to breathe was too strong," he confessed.

According to the Catholic Herald, many religious leaders are currently campaigning against the bill, including Cardinal Vincent Nichols of Westminster and Anglican Archbishop Justin Welby of Canterbury and 21 other of the most senior Christian, Jewish, Muslim, Hindu, Sikh, Buddhist, Zoroastrian and Jain leaders.

"This is not the way forward for a compassionate and caring society," the faith leaders wrote in a letter, signed also by Chief Rabbi Ephraim Mirvis of the United Hebrew Congregation of the Commonwealth and Dr Shuja Shafi, secretary-general of the Muslim Council of Britain.

"While we may have come to the position of opposing this bill from different religious perspectives, we are agreed that the Assisted Dying Bill invites the prospect of an erosion of carefully tuned values and practices that are essential for the future development of a society that respects and cares for all."