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 RODERICK MACLEOD ON BEHALF OF THE DEFENDANT

May 2015

Judicial Officer: Justice Collins
Next Event Date: Hearing commencing 25 May 2015

CROWN LAW
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I, Roderick Duncan MacLeod, of St Mary's Bay, Auckland, palliative care physician, solemnly and sincerely affirm:

1. I am a Senior Staff Specialist in Palliative Care at HammondCare in North Sydney and an Honorary Medical Officer at Royal North Shore and Ryde Hospitals. I am also a Conjoint Professor in Palliative Care at the University of Sydney and an Academic Director at the HammondCare Learning and Research Centre, Pallister House at Greenwich Hospital, Sydney.

2. I received my Medical Degree from the University of Dundee in 1976 and in 1980 I became a Member of the Royal College of General Practitioners. I received a Diploma of Medical Education in 1991 followed by a Master of Medical Education in 1992 both from the University of Dundee. I became a Fellow of the Royal College of General Practitioners in 1999 and a Foundation Fellow of the Australasian Chapter of Palliative Medicine in 2000. I received my PhD in 2001 from the University of Glamorgan/Prifysgol Morgannwg (now University of South Wales/Prifysgol De Cymru).

3. I have been involved in palliative medicine for over 25 years first becoming a full-time specialist in palliative care in 1989 with a responsibility for a large urban and rural population in south west England. While I was in the United Kingdom I also started to teach about end of life care.

4. In 1994 I moved to New Zealand to take up the position of Director of Palliative Care at the Mary Potter Hospice Foundation in Wellington. During my time in New Zealand I have worked as a Medical Director of Palliative Care in a range of hospices across the country.

5. In Wellington I also became involved in the teaching of medical students at the Wellington School of Medicine (professional development and practical ethics) and was also a member of the Medical Education Development Unit (MEDU) curriculum revision (New Pathway) at the University of Otago.

6. In 2003 I was appointed as New Zealand's first Professor in Palliative Care (South Link Health Chair) at the University of Otago, Dunedin School of Medicine. I have been active in education for generalists (particularly GP Continuing Medical Education), involved in teaching a number of postgraduate

courses (and undergraduates) at both the University of Otago and the University of Auckland and have produced interactive continuing professional education for general practitioners and other health professionals accessed via the Goodfellow Club website. I have also facilitated the development of a website for education of health care practitioners which can be found at www.palliativecarebridge.com.au. I am one of the authors of The Palliative Care Handbook which has been distributed to over 4000 health care practitioners throughout New Zealand and New South Wales.

7. I have published extensively on palliative care and related issues, including the specific challenges of providing palliative care for patients with brain tumours who may experience multi-focal neurological deficits such as hemiparesis, aphasia, visual field defects and dysphagia. Attached for example as **"Exhibit RDM-1"** is an article I have co-authored: Kunihiko Watanabe and Rod MacLeod "Care for Dying Patients with Primary Malignant Brain Tumour – Respecting Dignity" (2005) 45 Nurol Med Chir (Tokyo) 657.

8. Currently I am involved in the supervision of PhD students investigating a wide range of topics related to care near the end of life. I continue to teach on the graduate medical programme at the University of Sydney, in particular about palliative care and the nature of care near the end of life. I also have links with colleagues at the University of Auckland and AUT University, Auckland in the areas of exercise science and the assessment and measurement of quality of life as well as with the Patient-Centred Research Centre. I also work closely with colleagues at the University of Otago and the University of Sydney on aspects of spirituality in end of life care.

9. I attach a copy of my curriculum vitae as **"Exhibit RDM-2"**.

10. In this affidavit I address:

    10.1 Palliative care in New Zealand;

    10.2 The ability of palliative care to treat pain and suffering;

    10.3 The adverse implications of allowing physician assisted suicide and euthanasia in New Zealand.

11. I confirm I have read and understood the Code of Conduct for Expert Witnesses and I agree to comply with it. Further, I confirm any opinions I express in this affidavit are within my areas of expertise and experience.

Palliative care

12. Palliative care is a practice that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of identification, assessment and treatment of pain and other problems including physical, psychosocial and spiritual. It is based on a philosophy that acknowledges the inherent worth and dignity of each person. This requires that every facet of their being, not just the physical, should be understood and respected. As Sir William Osler wrote more than a century ago: "it is much more important to know what sort of person has the disease than to know what sort of disease the patient has." The article: Anna Janssen and Roderick MacLeod "What does care mean? Perceptions of people approaching the end of life" (2010) 8 Palliative and Support Care 433 addresses these ideas. A copy of this article is attached as **"Exhibit RDM-3"** to this affidavit.

12. Palliative care provides relief from pain and other distressing symptoms through incorporating treatment of physical symptoms with the psychological and spiritual aspects of patient care. The practice of palliative care operates to affirm life but acts to neither hasten nor postpone death. Palliative care offers a support system to both patients and their family to help them cope through the patient's illness and the grief and bereavement that results at the end of life.

13. Palliative care is provided by two distinct categories of health and social care professionals: those in generalist palliative care and those in specialist palliative care. Generalist palliative care is provided by those working to provide day-to-day care to patients, families and carers in their homes and in hospitals. Specialist palliative care is provided by professionals with additional training in the discipline and who only work in palliative care (consultants in palliative medicine and clinical nurse specialists in palliative care, for example).

14. While the physical symptoms of disease or illness can be treated through medication and other therapies, psychosocial care addresses the psychological and emotional wellbeing of patients and their family and friends. This

particularly focuses on the psychological experiences of loss and death for the patient and those close to them. It involves the spiritual beliefs, culture and values of those concerns and the social factors which influence the experience. It is intended to help the patient and their friends and family to deal with the process of death.

15. Palliative care also seeks to address the other symptoms and emotions that patients experience at the end of life. Autonomy has emerged as a modern criterion of moral worth providing the grounds to distinguish between being merely alive and being meaningfully alive. People's choices at the end of life are often different to those they may make earlier in their life. Patients' authority to choose what interventions they have, or to refuse interventions, is seen as one way of protecting dignity and autonomy. This provides patients with a sense of control that they may otherwise feel their illness or disease has taken from them. Respecting and reinforcing a patient's autonomy is a significant part of palliative care.

16. At the heart of palliative care is trust. Trust is a confident belief and reliance upon the ability and moral character of another person. It entails a confidence that another person will act with the right motives in accordance with moral norms. People with life-limiting illnesses, and their families and friends, need to be able to trust that their carers are, for example, telling them the truth.

17. Unskilled attempts to inform patients, however, have been described as the "assault of truth", for example in the often-quoted phrase "there is nothing more we can do." Such an approach serves to induce helplessness, hopelessness and despair in the patient and their family. As Elizabeth Latimer put it: "the door to any creative future is slammed shut and the patient has nowhere to look except death".

18. Communication and understanding are therefore critically important aspects of palliative care. Ensuring that patients and their families and loved ones understand what they are going through, what to expect, what their options are and their rights regarding treatment is fundamental to good practice. Communication and full understanding allow patients and their friends and family to make informed choices about their care and treatment and to fully engage and have control during what is a very difficult time in their lives.

19. Patients and families face a range of issues which are not only related to illness and approaching death. The healthcare professionals need to assess individual strengths and coping styles, experience and stress and attend to previous losses.

20. The initial assessment by a palliative care specialist will include a detailed medical/nursing assessment of the patient's and family/carers' needs. The time invested in this initial assessment is essential in creating a framework for the provision of future care; a partnership between patient and professionals. The initial assessment may indicate the need for more formal psychological, spiritual or social assessment. This will include the need to maintain autonomy which includes respect for dignity and the opportunity to exercise choice.

21. There are a multitude of assessment tools and techniques that can illuminate elements of psychosocial wellbeing and identify psychological, spiritual and social needs of patients and caregivers, including:

    21.1 *Beck Depression Inventory (BDI)*
    A 21-item multiple choice test used for assessing the presence and degree of depression in adolescents and adults.

    21.2 *Caregiver Strain Index*
    A tool that measures strain related to care provision. Used to assess individuals who have assumed the role of caregiver for an older adult.

    21.3 *Geriatric Depression Scale*
    A screening tool for symptoms of depression in the elderly.

    21.4 *Mini Mental State Questionnaire*
    A screening tool for assessing cognitive impairment.

    21.5 *Needs at the End-of-life Screening Tool (NEST)*
    NEST is a comprehensive assessment and outcome measures instrument.

    21.6 *FACIT*

The Functional Assessment of Chronic Illness Therapy (FACIT) measurement system is a collection of health related quality of life questionnaires targeted to the management of chronic illness.

21.7 *WHOQOL-SRPB*

The WHO quality of life SRPB field test instrument consists of 32 questions covering quality of life aspects related to spirituality, religiousness and personal beliefs.

21.8 *Palliative Care Outcome Scale (POS)*
A 10-item scale (plus an open question) that was specifically developed and validated for palliative care and covers physical symptoms, patient and family or caregiver anxiety/fears and well being.[1]

21.9 *Herth Hope Index*
A 12-item interview containing three dimensions: temporality and future, positive readiness and expectance, and interconnectedness; tested in community and hospital patients and family members.

22. Hope is a significant part of palliative care. The ability to maintain hope is an integral part of being a human being. For those suffering a terminal illness or who are at the end of their lives hope is understandably a difficult thing to maintain. Towards the end of life it is often assumed that 'there is no hope'; indeed that language has been used by clinicians in the past. I address the importance of hope in palliative care in the article: Rod MacLeod and Helen Carter "Health Professional's perception of hope: understanding its significance in the care of people who are dying" (1999) 4 Mortality 309. A copy of this article is attached to this affidavit as **"Exhibit RDM-4"**.

23. There are a number of common elements that run through the literature on hope. These are often related to the social, spiritual or existential dimensions of being, rather than the physical, including:

23.1 the provision of effective relief from distressing symptoms;

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[1] A comprehensive list of such tools may be obtained from a number of sources including http://www.npcrc.org/resources/resources

23.2 the perceived existence of a positive future for the patient and his or her family;

23.3 the patient's feeling that he or she is valued as a person, and

23.4 the redefinition of the patient's goals as he or she moves through the disease process.

24. A major threat to maintaining hope is the individual's loss of control over significant present circumstances, which threatens the existence of any future.

25. There are a number of frameworks of how to help people develop hope. For example, Morse and Doberneck identified seven components in the process of developing hope:

25.1 A realistic assessment of the predicament or threat;

25.2 The envisioning of alternatives and the setting of goals;

25.3 The bracing for negative outcomes;

25.4 A realistic assessment of personal and external resources;

25.5 The solicitation of mutually supportive relationships;

25.6 The continuous evaluation for signs that reinforce the selected goals;

25.7 The determination to persevere.

26. Fifity years ago Aaron Beck proposed that hopelessness was the variable linking depression to suicidal behaviour. Hopelessness captures two core elements:

26.1 Negative expectations about the occurrence of highly valued outcomes; and

26.2 Expectations of helplessness about changing the likelihood of coccurence of these outcomes

27. Palliative care aims to restore, build or maintain hope in the patients within its care as well as for their family and friends. This assists with the patients' and

their loved ones' spiritual and emotional wellbeing. For example, rather than hoping for a cure or remission from disease, hope can be focussed on more immediate aspects of life such as hope for a good night's sleep or hope to feel the touch of a loved one again. This refocussing of hope is an integral part of palliative care provision.

28. In my experience I have found it is often common for patients to express a desire to terminate their lives early or want euthanasia or physician assisted suicide in the early stages of their illness or in the initial phase following a terminal diagnosis. However in my experience palliative care patients almost never persist with requests for euthanasia once they are receiving palliative care and have had time to adjust to their new situation.

Palliative Care in New Zealand

29. Palliative care is now widely available in New Zealand. Since the 1970s hospices have been established in most regions, and palliative care has become recognised as a specialty in its own right. While there is still much to be done worldwide in terms of research, development of assessment and treatment regimens, workforce training, and equitable access to services, New Zealand has earned an excellent reputation for the quality of its palliative care services in hospices, hospitals and the community. Most New Zealand health practitioners will be aware of the services available in their district and should be able to make referral easily.

30. It has been assumed (wrongly) in the past that palliative care is only for people with cancers. This is not so. It is available to anyone with a life-limiting illness. Similarly, it is assumed (wrongly) that palliative care is predominantly for older people. Anyone can access palliative care, at any age. Indeed palliative care is provided for children in New Zealand as well as young adults and older people. Services vary from community based services through to in-patient programmes of care depending on location. Each service will have a multidisciplinary approach to care and will include the patient, their family and their primary health care team in the planning of care.

31. Each patient provides a unique challenge for the provision of palliative care. Whilst patients may present with similar pathologies, each person and their

family will have differing needs, fears, hopes and aspirations. Caring for people with brain tumours presents a particular set of problems that relate to the presence of a space occupying lesion in the brain with consequent challenges but each situation is taken on its own merit and a plan made accordingly. My clinical role in Sydney afforded me the opportunity to care for a large number of people with brain tumours each of which was challenging in its own way.

Pain relief

32. Pain in end of life care, as well as in other contexts, is multidimensional. It is a symptom involving physical, psychological, social and spiritual components. In order to effectively treat or manage pain it is important to see it and address it in its totality.

33. It is not possible to say that all pain in all cases can be removed, however in most cases palliative care is able to effectively manage or alter pain. According to a 1996 World Health Organization document, there were already then available methods for relieving pain in up to 90 per cent of patients (World Health Organization (1996) *Cancer pain relief* (2nd ed) Geneva, 14).

34. Physical pain is usually easy to identify and most often able to be treated or managed. Physical pain is almost never irremediable. The psychological, spiritual and social aspects of pain, however, are more difficult to identify and treat in patients in end of life care. This is for the reason that they are often more subjective and difficult to measure and in some cases are not able to be treated or managed with medications. Further, physicians untrained in palliative care are not always good at recognising the social or spiritual dimensions of pain – for example the pain associated with loss or fear.

Suffering

35. The broader suffering of terminally ill patients is a difficult concept to grasp. Suffering is inherently unique to individuals and is quite different to the presence of pain. Relief of pain will not always relieve suffering. Suffering includes holistic suffering, which can be multidimensional, oscillating, individual and difficult for individuals to express. Opportunities should be provided for patients to express their suffering. The potential for suffering to be transcended needs to be recognised and facilitated by healthcare staff.

36. The importance of accurate assessment cannot be underestimated. The multidisciplinary team needs to ensure they all contribute to the assessment of suffering. The patient will identify what this is and so listening is a core component on this assessment. By addressing each aspect of a person's being (what makes them who they are) attempts can be made to address the issues of suffering whether they be physical (using medication for example), psychological (using some form of psychological counselling for example), social (with the help of medical social workers) or spiritual (again by accurate assessment and ongoing supportive attention).

Palliative sedation

37. Palliative sedation is a strategy of last resort in palliative care. It is used to minimise distressing refractory symptoms that are difficult to manage. In my experience it is used very rarely, only where there is intractable suffering and the person is near the end of their life. It should only be used with the informed consent of the patient and family.

38. There is a common misconception that palliative sedation hastens death and some argue that this already amounts to euthanasia. This is incorrect. Palliative sedation does not hasten death. The aim of treatment is to 'mask' or 'cloak' (the literal translation of the verb to palliate) the symptoms; to reduce awareness of pain or breathlessness for example. The medications used are generally short-acting sedatives, used at a dose to reduce awareness not at a dose to halt breathing. It is also reversible.

39. The intention behind sedation therefore is to sedate, calm and to reduce the anxiety and distress of the patient. There is no intention to hasten the patient's death or that the patient's death should be brought about by such sedation. In all palliative care practice the intention is to enhance the quality of the patient's life by preventing and relieving suffering.

Continuing improvement in palliative care in New Zealand

40. New Zealand is fortunate to have an advanced practice of palliative care. The quality of palliative care available in New Zealand and access to palliative care is some of the best in the world. Attached as **"Exhibit RDM-5"** to this affidavit is an article: Takashi Yamaguchi et al "Palliative Care Development in the Asia Pacific region: an international survey form the Asia Pacific Hospice

Palliative Care Network (APHN)" (2014) BJM Supportive and Palliative Care 1.[2]

41. Palliative care and the practice of palliative medicine is an emerging field of medicine. It is only over the last 40 years that palliative medicine has been recognised as a discrete area of medicine. During this period there have been great advances in palliative care both in the understanding and development of it as a practice as well as in the available medical technologies that it can utilise. However, as an emerging practice there is still room for improvement and advancement in palliative care.

42. There is a need for more and better education in cancer pain management and palliative care at undergraduate and postgraduate levels, through enhancement of existing education, introduction of new programs, and better integration throughout New Zealand. This is addressed in the article: Rod MacLeod "Challenges for education in palliative care" (2004) 12 Progress in Palliative Care 117. A copy of this article is attached as **"Exhibit RDM-6"** to this affidavit. There have been real advances made in several of these areas, in particular by the development of the Royal Australasian College of Physicians Chapter of Palliative Medicine and the development of new programs to enhance the palliative approach. However, we continue to be faced with many challenges. Palliative care education has been diverse and imaginative, at times highly focussed and specific, at others more wide ranging and all-encompassing. Creative and culturally specific responses to the challenges of education are more likely to succeed than imposed formulae and concepts.

43. Education for all health professionals will not only improve knowledge and skills in this area but it will increase the levels of understanding in the community about what palliative care can realistically do. At present for example, referrals come late to many services, leaving little time to deal with the issues presented. One example of an effective initiative is the Hospice NZ Fundamentals of Palliative Care programme that provides education to staff at residential aged care facilities thereby ensuring widespread knowledge and understanding of the principles and practice of palliative care across the sector.

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[2] See also report by the Economic Intelligence Unit commissioned by the Lien Foundation which rated New Zealand as 3rd in the world for quality of end of life care: http://graphics.eiu.com/upload/eb/qualityofdeath.pdf.

44. Another aspect of improvement lies in improving access to palliative care for people with non-malignant diseases. Currently, a majority of people referred for palliative care have malignant disease and yet only one out of three people dying in New Zealand do so from a malignant illness. All people with a life-threatening illness should have access to the benefits of a palliative care approach.

45. Currently, New Zealand palliative care relies heavily on charitable funding. Recent governments have contributed more of the true cost of the provision of palliative care but most services still rely heavily on raising over one third of their operating costs to provide care to their communities. Hospice NZ has lobbied effectively for increased funding but more needs to be done to ensure that all New Zealanders have access to palliative care when they need it.

Adverse impacts of legalising assisted suicide or euthanasia

46. Physician assisted suicide and euthanasia would have far reaching implications that extend well beyond the immediate setting of individuals seeking assistance to end their own lives. Dying under these circumstances does not and cannot occur in isolation from friends, family, medical staff and society. The rights of those who wish to access physician assisted death services must be considered in light of the rights of many others who will be affected by the death requested. I set out my views on this in more detail in the submission I co-authored to the Australian Senate Legal and Constitutional Affairs Legislation Committee on the Medical Services (Dying with Dignity) Bill 2014, a copy of which is attached to this affidavit as **“Exhibit RDM-7”**.

Risks to the terminally ill

47. At a basic level, there is a risk that if assisted suicide and euthanasia are deemed acceptable then people, particularly in the early stages of their illness, will choose it as an alternative to engaging with palliative care, without due consideration or understanding. People who may have otherwise benefited from palliative care may end their lives much earlier and in more distressing circumstances.

48. Conversely, people may incorrectly link palliative care and physician assisted suicide and euthanasia, and be reluctant to engage with palliative care because

of a fear that they may be pressured or encouraged to end their lives prematurely.

49. Assisted suicide and euthanasia have the potential to undermine drastically the respect for and quality of life for people in vulnerable circumstances, and to place pressure on them to justify their continued existence.

50. There is often the suggestion that assisted dying can only be undertaken on a 'voluntary' basis. However, there will inevitably be pressures on individuals who are already weak and vulnerable to seek this remedy for fear of being a burden on their families or on society. Not all families are readily able to cope with the prospect of a lingering end to life and may inadvertently put pressure on a vulnerable individual to end it all sooner rather than await a natural outcome.

51. Often, in my experience, the desire for death is a fluctuating one. On some days people seem more ready to accept their dying and on others, less so. Dying can be hard; dealing with the losses one is facing is one of the most challenging periods of one's life without the added pressure of thinking about whether or not to seek an early death from day to day. There may well be unspoken pressures from families or health professionals that interfere with the 'work' of dying. Not all families are compassionate and caring at this time.

Assessing the competence and capacity of patients requesting early death

52. Assessing whether a person facing a life limiting illness has the capacity and competence to make such a significant decision would pose a significant challenge. There is little consensus at present about how easy it is to assess competence in very ill people and many clinicians are wary of dealing with this aspect of health care. People near the end of life are dealing not only with extensive physical illness but also the immense psychological, and spiritual burden of approaching the end of their lives.

53. Further there is no consensus regarding the best way to assess the competence of patients to make such a final decision or even when or how such an assessment should be made.

54. Physicians also are not necessarily able to assess whether a patient is being coerced: this is simply not a medical issue. Nor is it within the scope of our expertise or training to be able to assess whether a patient is under more subtle forms of pressure from family or others, or indeed whether a decision to die early and not allow a natural death is in all respects freely made.

55. Mental health and psychiatric conditions of patients requesting physician assisted death services, for example clinical depression, can also be problematic and difficult for physicians to identify. Even qualified psychiatrists cannot always easily identify or determine that a patient may be suffering from some sort of mental health or psychiatric condition which may affect the capacity of patients expressing a desire for assisted death. In Oregon a survey of psychiatrists identified that 94 per cent did not feel that they were able to decide whether a mental disorder was influencing a request for physician assisted suicide after just one consultation. Experts in the field have expressed the view that one of the biggest concerns about assisted dying is the inability of psychiatrists to determine which patients are suitable, and which are unsuitable for physician assisted death services.[3]

56. If specialist psychiatrists are not able to make such judgements then it seems highly unlikely that GPs will be able to do so.

Impact on the medical profession

57. Legalising physician assisted suicide and euthanasia would have fundamental implications for the medical profession.

58. Doctors will be asked to take active steps to end a human life. This is directly contrary to our fundamental obligations and duties. I have heard it suggested that doctors should be involved because it is too much to expect lay people to take responsibility for ending a life. I do not understand why it is thought that doctors would find this less damaging.

59. Enabling physicians to assist patients to die will fundamentally change the existing role of doctors and healthcare practitioners. The current role of doctors and the ethical obligation they are under is to protect the life and

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[3] Sandy MacLeod "Assisted dying in liberalised jurisdictions and the role of psychiatry: A clinician's view" (2012) Australian and New Zealand Journal of Psychiatry 1

health of their patients. Doctors are educated to preserve life, not to take it. To involve doctors in the process of bringing about a patient's death would require a significant change in focus for practitioners who choose to undertake it as well as a significant shift the role they fulfil, and are perceived as fulfilling in society.

60. Legalising physician assisted suicide and euthanasia will also have effects on the medical practitioners administering these services. The shift from promoting care towards playing an active role in hastening death can have a profound impact on the doctors themselves and the staff that work with them. There is evidence that significant proportions of doctors who have taken part in euthanasia or assisted suicide in jurisdictions where it is permitted have experienced adverse consequences including feelings of discomfort and regret. In some cases doctors have even reported that their response to assisting patients to end their life has had negative impacts on their ability to practice medicine.

Impact on the patient-doctor relationship and the practice of palliative care

61. Legalisation of physician assisted suicide and euthanasia will also bring about changes in the doctor-patient relationship. If as well as promoting quality of life and protecting the health of patients medical practitioners also begin to perform euthanasia, this will undermine the trust between other patients and their doctors. Doctors already hold the balance of power in that relationship – such moves to include physicians in the ending of life will necessarily increase that imbalance of power.

62. Legalising physician assisted suicide and euthanasia will also have significant negative implications for the practice of palliative care.

63. The public's (and some of the profession's) understanding of palliative care is already limited. If the public thought that those providing palliative care might also be those who undertake assisted dying they may well be reluctant to seek help from those who know best how to alleviate their symptoms. In surveys of doctors to seek their views on assisted dying it is always the palliative care community who are most vocal in opposing such practices. And that is the group who knows better than any how effective palliative care can be. If

assisted dying were available there would inevitably be added confusion about the role of palliative care as the end of life approaches.

64. On a broader level, the development of an accepted practice of assisted suicide and euthanasia could have significant effects on the provision and perceptions of palliative care services. Palliative care services may be devalued and there is a risk that this might result in inadequate resourcing of and access to essential quality palliative care services. This may also result in diminished funding for hospice and palliative care. New Zealand's palliative care services are far from mature and this could significantly affect their ongoing development and the advances that are already underway.

65. Just as patients are individuals, so too are doctors, nurses and other carers. Recruiting and retaining the palliative care workforce is difficult enough given the challenges inherent in looking after people approaching death. For example, a 2002 study by Brorsson et al showed that as medical students gained clinical experience they became less interested in conditions where cure was not possible or where the condition was chronic or affected the person's appearance or behaviour.

66. If physician-assisted suicide and euthanasia is legalised it will place palliative care specialists in an invidious position that will have the effect of deterring some people from entering the field. (Even worse would be if it <u>encouraged</u> some people to enter the field.)

67. To accompany people when they are at their most vulnerable and frightened can be hard work, and it is not something that everyone can or will want to do. Each day brings new challenges and threats for the patient, their families and their carers. For those who are sick it is one of the most challenging times of their lives and yet paradoxically it can be one of the most rewarding. The privilege of working with those people and their families is immense. The job of the palliative care specialist is to guide, reassure and comfort not only those who are dying but also those who love and care for them. It is the job of those who accompany people who are dying to help to rekindle hope, to minimize fear and to never abandon them.

68. Euthanasia, or assisted dying in any form, is therefore antithetical to the purpose and practise of palliative care.

AFFIRMED
at Auckland this day of)
May 2015 before me:)

Roderick Duncan MacLeod

A Solicitor of the High Court of New Zealand