

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

REPLY AFFIDAVIT OF KATHERINE TERESA MORRIS
AFFIRMED 19th MAY 2015

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I, **KATHERINE TERESA MORRIS**, surgical oncologist, of Albuquerque, New Mexico, United States of America affirm:

Introduction

1. I am a surgical oncologist, residing in Albuquerque, New Mexico, United States of America. I am also an assistant professor at the University of New Mexico, where I undertake cancer research.
2. I have previously provided an affidavit in this proceeding and I refer to that affidavit.
3. The purpose of this affidavit is to set out my views on the effects of aid in dying ("AID") with respect to the recurring argument that:
 - (a) AID would fundamentally change the physician/patient relationship;
 - (b) AID would be bad for patient engagement with palliative care services; and
 - (c) AID would be inconsistent with the ethos of palliative care more generally.

The physician/patient relationship

4. The argument that AID will fundamentally change the nature of the physician/patient relationship does not make sense to me.
5. In my view, the most fundamental aspect of the physician/patient relationship is the imperative to meet the individual patient's health care needs. In this respect, the medical community does the very best that it can.
6. If the medical community is not able to offer a cure, or extend life with good quality (as defined by the patient), and the patient's goal is a modicum of control over their dying process, then AID seems to represent a natural continuum of the physician/patient relationship.
7. In those circumstances, AID is the physician seeking to help the patient meet their health care goals to the best of their ability.

Patient engagement with palliative care

8. The argument that AID would be bad for patient engagement with palliative care services is contrary to the experience in Oregon.
9. In Oregon, there was an increase in hospice referrals and enrolments following the passing of the Death with Dignity Act 1997 ("DWDA").
10. Additionally, as stated at [16] of my first affidavit, Oregon's palliative care "rating", as assessed by external bodies, improved following the passing of the DWDA.
11. I would like to reiterate my view that there is no conflict between palliative care and AID, they are complementary practices.



The ethos of palliative care

12. AID does not conflict with the ethos of palliative care. Palliative care is defined by the World Health Organisation as follows:¹


Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual

13. I see nothing in that definition that conflicts with the practice of AID when a mentally competent, terminally ill, adult requests it. That is supported by my experience, set out at [17] of my first affidavit, of AID facilitating engagement with palliative care.
14. As stated in my first affidavit at [7] I have prescribed drugs under the DWDA for two patients.
15. Both of those patients clearly stated multiple times that the availability of AID was of great comfort to them because it alleviated their anxiety and a loss of self as their illnesses progressed. They both said they received psychosocial benefit from knowing they had this option available to them.

AFFIRMED at Albuquerque, New Mexico,
United States of America this 19th day of
May 2015 before me:



Katherine Teresa Morris



A person duly authorised to administer
oaths in New Mexico



¹ World Health Organisation "WHO Definition of Palliative Care"
<<http://www.who.int/cancer/palliative/definition/en/>>.