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 DR AMANDA LANDERS ON BEHALF OF THE DEFENDANT

Sworn May 2015

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

CROWN LAW
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I, Amanda Lorraine Landers, of Christchurch, physician, swear:

1. I am a Community Palliative Care Physician with the Hospice Palliative Care Service in Christchurch, and a Senior Clinical Lecturer at the University of Otago, Christchurch. I am a Fellow of the Royal Australasian College of Medicine, Palliative Medicine.

2. I am the Chair of ANZSPM Aotearoa, the New Zealand section of the Australian & New Zealand Society of Palliative Medicine Inc.

3. I make this affidavit on behalf of ANZSPM Aotearoa.

The Australian and New Zealand Society of Palliative Medicine

4. The Australian and New Zealand Society of Palliative Medicine is a not-for-profit specialty medical society for medical practitioners who provide care for people with a life-limiting illness in both Australia and New Zealand.

5. ANZPM has approximately 420 members in Australia and New Zealand. The organisation held its 20th annual conference last year.

6. ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses, and support their families. ANZSPM members are medical practitioners. They include Palliative Medicine Specialists, doctors training in the Palliative Medicine discipline, General Practitioners and doctors who are specialists in other disciplines such as oncology.

7. ANZSPM's objectives are to:

    7.1 Provide a forum for Registered Medical Practitioners engaged in the practice of Palliative Medicine or related disciplines to facilitate their professional development and to provide mutual support.

    7.2 Advance the discipline of Palliative Medicine.

    7.3 Provide a voice on policies relating to Palliative Medicine.

    7.4 Promote undergraduate and postgraduate education and training in Palliative Medicine and to support Palliative Medicine Trainees.

7.5 Promote research in and evaluation of medical and related issues in Palliative Medicine.

7.6 Liaise with other relevant bodies.

8. ANZSPM embraces the definition of Palliative Medicine adopted in Great Britain in 1987: "Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life."

9. It is a fundamental tenet of palliative medicine that it neither hastens or prolongs life.

10. ANZSPM and its members also aspire to:

10.1 Promote collaborative partnerships

10.2 Enable quality outcomes for patients and families/whanau

10.3 Support quality work environments

10.4 Recognise the diversity of our members and all Palliative Medicine practitioners

10.5 Have equity of access to Palliative Medicine

10.6 Ensure that medical practitioners are an essential part of palliative care.

The Australian and New Zealand Society of Palliative Medicine is opposed to physician assisted suicide and euthanasia under any conditions

11. In 2013, the ANZSPM membership of approximately 420 doctors across Australia and New Zealand were surveyed directly about their views on the practice of euthanasia and physician-assisted suicide. The previous position statement drafted in 2010 did not provide clarity on its stance. Dr Frank Brennan, who was the current President of ANZSPM, drafted an alternative position statement and circulated this to all members. Three months was given for careful thought and consideration towards a vote on whether to adopt the new position statement. Submissions were invited and encouraged. The stated aim was to make the process as open, transparent and democratic as possible,

and to allow the ultimate vote to be fully informed and conducted with all opportunity for thought and debate.

12. ANZSPM members in both Australia and New Zealand voted with a decisive majority in favour of adopting the new *Alternate Position on The Practice of Euthanasia and Assisted Suicide*. The ANZSPM Council endorsed that position statement as ANZSPM's new and current position statement. It is very succinct and very clear:

> (a) The discipline of Palliative Medicine does not include the practice of euthanasia or assisted suicide;
>
> (b) ANZSPM endorses the World Medical Association Resolution on Euthanasia, adopted by the 53rd WMA General Assembly, Washington, DC, USA, October 2002, which states: "The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and the World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions."
>
> (c) ANZSPM opposes the legalisation of both euthanasia and assisted suicide.

13. As stated in the position statement, ANZSPM confirms the strong belief that euthanasia and assisted suicide is in conflict with basic ethical principles of medical practice.

14. Legalising physician assisted suicide or euthanasia under any conditions would also compromise the effective delivery of palliative care and place at risk the most frail and vulnerable patients the medical profession has the privilege to care for.

15. Palliative Care affirms life and regards dying as a normal process. It improves the quality of life of patients and their families facing the problems associated with life-limiting illness. It aims to prevent and relieve suffering by means of early identification, and assessment and treatment of pain and other problems – physical, psychosocial and spiritual. It is about life, not death.

16. I understand that the plaintiff's counsel in this case has argued that the case will not affect medical ethics because doctors will not be forced to engage in physician assisted suicide if they choose not to participate. This misses the point: our opposition to physician assisted suicide and euthanasia is not based on personal values. Our position statement reflects the strong belief that

physician assisted suicide and euthanasia are contrary to the fundamental tenets of medical practice and inherently harmful.

ANZSPM's position is consistent with the New Zealand Medical Association's opposition to euthanasia and doctor assisted suicide

17. The New Zealand Medical Association position statement, approved in 2005, states:

> The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide.
>
> Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical.
>
> Doctor-assisted suicide, like euthanasia, is unethical.
>
> The NZMA however encourages the concept of death with dignity and comfort, and strongly supports the right of patients to decline treatment, or to request pain relief, and supports the right of access to appropriate palliative care.
>
> In supporting patients' right to request pain relief, the NZMA accepts that the proper provision of such relief, even when it may hasten the death of the patient, is not unethical.
>
> This NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical.

The World Medical Association position statements

18. The World Medical Association (WMA) is an international organization representing physicians. As it records on its website, it was founded on 17 September 1947, when physicians from 27 different countries met at the First General Assembly of the WMA in Paris. The organization was created to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians, at all times. This was particularly important to physicians after the Second World War, and therefore the WMA has always been an independent confederation of free professional associations.

19. The WMA provides ethical guidance to physicians through its Declarations, Resolutions and Statements. These also help to guide National Medical Associations, governments and international organizations throughout the world.

20. Membership of the WMA currently stands at 111 National Medical Associations.

21. The World Medical Association's Declaration on Euthanasia was adopted by the 53rd WMA General Assembly, Washington DC, USA, in October 2002 and reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013. It states:

> Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.

22. The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 likewise states:

> Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically, even if respecting such a wish results in the death of the patient.

Withdrawal of treatment is not euthanasia

23. The basic ethical principles that govern medicine include patient autonomy, beneficence or simply do good, non-maleficence (do no harm), justice and futility. A competent patient is able to decide to stop treatment of any form. Equally, a medical practitioner is able to withdraw a treatment that is deemed to be futile. This results in the disease progressing on its natural course. It is helpful to remember that for many conditions, patients would not ever have survived without modern medicine 'artificially' keeping them alive. Therefore stopping a treatment is not a decision to actively cause death. Rather, it is a decision to allow a natural death (AND).

24. In stark contrast, euthanasia and assisted suicide always and actively seeks death. While some members of the public and some advocates for euthanasia may not understand the distinction, as highlighted by the WMA position statements above, medical professionals and ethicists are clear that the distinction is absolute.

Doctors in New Zealand are not 'killing patients anyway'

25. A doctor in New Zealand who acted deliberately to end the life of his or her patient would be acting unethically and committing a serious criminal offence.

26. I am aware that there is a perception in some groups that euthanasia or physician assisted suicide is happening in New Zealand anyway. This is usually linked with opioid use, particularly Morphine. Morphine is an excellent medication for pain but is also used first line for breathlessness. Very few people are aware of this and some colleagues are also not up to date with this practice. Doses should be increased with the intent of ameliorating a symptom and when this is done correctly is well-tolerated. It is an enabler; it enables patients to live better. When titrated correctly the amount is not really important. It may be that a patient requires 100s of milligrams of Morphine, but if this allows good symptom management it is acceptable.

27. The doses may increase, generally over days, weeks or months. In these situations it is actually very hard to cause a terminal event with the opioid itself. Unfortunately, sometimes doctors who are not specialists in palliative care believe the doses and increases are what are causing the deterioration where for the vast majority of cases it is actually the disease. An inadvertent overdose of opioid will generally cause sedation, and will be reversed by with-holding further medication and sleep. For the rare occasion it is given for a genuine symptom and it suppresses the breathing as someone is dying, this is allowed for both in law and medicine. It is called the 'double effect.' The intent is comfort and not death.

28. Again, while some members of the public and some advocates for euthanasia may not understand the distinction between providing symptom relief and causing death, that does not mean that the distinction does not exist. Medical practitioners, and especially those of us practising in the palliative care specialities, are very clear on the difference between the two.

SWORN

at Christchurch this 4 day of May 2015
before me: Cath Marsh JP
Flat 3. 58 Bishopst
St Albans
Christchurch.
Cath Marsh JP

Cath Marsh, J.P.
#9070
CHRISTCHURCH
Justice of the Peace for New Zealand

A. Landers.
Amanda Lorraine Landers

A Solicitor of the High Court of New Zealand