
**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

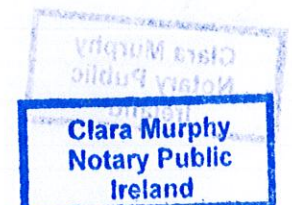
Defendant

**AFFIDAVIT OF PATRICK ANTHONY (TONY) O'BRIEN ON BEHALF OF
DEFENDANT**

[Date]

**CROWN LAW
TE TARI TURE O TE KARAUNA
PO Box 2858
WELLINGTON 6140
Tel: 04 472 1719
Fax: 04 473 3482**

**Contact Person:
Paul Rishworth QC
Email: paul.rishworth@crownlaw.govt.nz**



I, **Patrick Anthony (Tony) O'Brien**, Consultant Physician in Palliative Medicine, Marymount University Hospital & Hospice / Cork University Hospital / College of Medicine & Health, University College Cork, make oath and say:

1. My name is Tony O'Brien. I have worked exclusively in the field of palliative medicine since July 1986. I took up my current clinical appointment in December 1991 and I was appointed Professor of Palliative Medicine at University College Cork in February 2014.
2. I was an expert witness for the State of Ireland at the High Court trial in *Fleming v Ireland* [2013] IEHC 2, heard in December 2012 and decided in January 2013. The judgment was subsequently affirmed in the Irish Supreme Court ([2013] IESC 19).
3. I have been asked to give evidence concerning:
 - 3.1 the nature of, and my experience in, palliative care;
 - 3.2 the nature of suffering in the terminally ill;
 - 3.3 my experience arising out of persons who are suffering and who express a wish to die or have their life ended;
 - 3.4 the impact on society and patient care of any move to assisted suicide or euthanasia; and
 - 3.5 the concept of palliative sedation.
4. To the extent that my affidavit expresses my opinions, I confirm that these are within my areas of expertise and experience. I confirm that I have read the High Court Code of Conduct for Expert Witnesses in schedule 4 of the High Court Rules and I agree to comply with that Code.
5. In preparation for making this affidavit I have read the affidavit of the plaintiff and her General Practitioner and Oncologist. I have also been provided with copies of affidavits by Rajesh Munglani and Michael Ashby.



Current and past positions

6. I am a Consultant Physician in Palliative Medicine at Marymount University Hospital & Hospice and at Cork University Hospital, Ireland. I am professor of palliative medicine at the College of Medicine & Health, University College Cork, Ireland.
7. I am a Fellow of the Royal College of Physicians of Ireland and a board member of the Association for Palliative Medicine of Great Britain and Ireland. I am a board member of the Faculty of Pain Medicine, College of Anaesthetists of Ireland.
8. I previously chaired the Council of Europe Expert Committee on Palliative Care, the Irish Association for Palliative Care, the National Advisory Committee on Palliative Care (Ireland) and the National Council for Specialist Palliative Care (Ireland). I am currently a director of the Napp Educational Foundation.
9. I have published fourteen book chapters and have authored or co-authored multiple journal publications. I have lectured nationally and internationally on matters pertaining to palliative care.
10. My curriculum vitae is attached to this affidavit marked "PAO-1".

Definition of palliative care

11. For the sake of clarity, I wish to begin by quoting the World Health Organisation (2002) definition of palliative care as follows:

Palliative Care is an approach that improves 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 early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual.

Palliative Care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;

- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, as indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Council of Europe Expert Committee on Palliative Care

12. I chaired the Council of Europe Expert Committee on Palliative Care. Recommendation REC (2003) 24 of the Committee of Ministers to member states on the organisation of palliative care was adopted by the Committee of Ministers on the 12th November 2003 at the 860th meeting of the Ministers' Deputies. This document highlights a number of important principles as follows:

- Palliative care is a vital and integral part of health services.
- Any person who is in need of palliative care should be able to access it without undue delay, in a setting which is, as far as reasonably feasible, consistent with his or her needs and preferences.
- Palliative care has as its objective the achievement and maintenance of the best possible quality of life for patients.
- Access to palliative care should be based on need and must not be influenced by the disease type, geographical location, socioeconomic status or other such factors.
- Specialist palliative care should be available for all patients when they need it, at any time and in any situation.
- Palliative care affirms life and regards dying as a normal process.
- Palliative care intends neither to hasten nor postpone death.

13. Palliative care is life enhancing, life enriching and life sustaining in its focus. Any attempt to address the complex and multi-faceted nature of human suffering and distress by acting with the intention to end a person's life,



however well-intentioned or otherwise, does not fall within the compass of palliative care. Palliative care views dying as a normal, integral and inevitable aspect of life and living. Palliative care seeks at all times to enable people to live the life they choose to live, in the manner and setting of their choice.

14. Whilst embracing and applying as appropriate all of the available medical and technological advances for the purpose of supporting patients in their illness, palliative care seeks to apply such technologies in a balanced and measured way. In medicine, the fact that something can be done does not necessarily mean that it should be done.
15. Doctors are not obliged to continue treatments that are patently futile and are excessively burdensome to the patient. Equally, patients are entitled to refuse any and all medical treatment and advice, irrespective of the anticipated consequences. In palliative care, the objective is to ensure that patients have the highest possible quality of life. At the point when the disease process is bringing that life to a natural end, patients must be able to receive every possible measure of physical, emotional and spiritual comfort. Euthanasia and physician assisted suicide are not part of good palliative care.
16. In particular, I note the following extract from the Council of Europe report:

Specifically, attention is drawn to the fact that euthanasia and physician assisted suicide are not included in any definition of palliative care; for that reason, the committee does not take a stand on these issues.

Palliative care provision in Ireland

17. The speciality of palliative medicine was recognised in the United Kingdom in 1987 and in Ireland in 1995. At the time, Ireland was only the second country in Europe to recognise and to promote the development of palliative medicine as a distinct specialty. To the best of my knowledge, other countries have adopted palliative medicine as a specialty or subspecialty area as follows:

- 17.1 New Zealand (2001);
- 17.2 Australia (2005);
- 17.3 United States of America (2006);
- 17.4 Germany (2006); and



17.5 France (2007).

18. Thus, Ireland is at the forefront of palliative care service development and provision. We have a long and proud tradition of hospice care dating back to the opening of St. Patrick's Hospital, Cork (1870) and Our Lady's Hospice, Harold's Cross, Dublin (1879) by the Irish Sisters of Charity. The work of the Irish Sisters of Charity was pivotal in this regard and particularly in the context of their sister unit, St Joseph's Hospice, which opened in Hackney, London in 1905. Dame Cicely Saunders, the founder of the modern hospice movement, conducted her early research and development work at St Joseph's. Dame Cicely subsequently opened St Christopher's hospice in Sydenham, London as the first of the modern clinical, research and teaching hospices. It is often acknowledged that hospice care was born in England but was conceived in Ireland. Ireland was one of the first countries to produce a national strategy for the appropriate development and integration of palliative care throughout the health and social care system. By any international standards, Ireland is at the leading edge of palliative care provision and development.

What percentage of suffering can palliative care currently relieve?

19. The term "suffering" is a complex, subjective and multi-faceted phenomenon that reflects the individual's physical, social, emotional and spiritual well-being. Suffering is a dynamic phenomenon and the individual experience of suffering may alter quite radically in response to changes in an individual's physical, emotional and spiritual wellbeing. It is essential to distinguish the phenomenon of suffering from the more narrow concept of physical pain. Dame Cicely Saunders, the founder of the modern hospice movement, coined the term "total pain" to capture this multi-faceted experience incorporating elements of a physical, emotional, social and spiritual nature. These various elements are inextricably entwined and each may influence the other. We recognise that modern pain medicine can provide significant control of symptoms to the vast majority of patients. However, it is equally recognised that there are sources of individual distress that are not responsive to analgesic drugs or interventions. This type of distress requires a different response focusing on providing appropriate psychosocial, emotional and spiritual support. In traditional medical training, the emphasis is placed primarily on the 'physical' aspects of pain management in the classical biomedical model.

Clinicians who are not trained and experienced in addressing the psychosocial, emotional and spiritual aspects of suffering may rely excessively and with limited success on pharmacological and purely 'medical' type of interventions. Such a narrow reliance is unlikely to yield optimal outcomes.

20. A common feature in "suffering" is the phenomenon of spiritual anguish or distress. Underpinning all spiritual anguish is an inability on the part of the affected person to find any meaning of purpose in their life, in their illness or in their dying. There is no drug therapy that can provide such meaning. The most attentive and competent physician cannot prescribe meaning to an individual patient. However, by a process of skilled and compassionate care, one attempts to create the necessary circumstance whereby the individual patient may themselves find some degree of meaning in their suffering. Even in the most extreme situations imaginable, the individual may find meaning and purpose in life's suffering as evidenced by the writings of the psychiatrist and concentration camp survivor Victor Frankl:

Man is not destroyed by suffering; he is destroyed by suffering without meaning.

Physician Assisted Suicide and Active Voluntary Euthanasia

21. In my opinion, the greatest strength of the current legislative position in Ireland on physician assisted suicide and active voluntary euthanasia is that it is abundantly explicit and clear. Doctors and other carers, professional and informal, understand that they are not entitled to take any course of action that is designed and intended to cause the death of a person, however well-intentioned they believe their motive might be. In Ireland, the Criminal Law (Suicide) Act 1993 states that a person who "aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence". This is a vitally important safe-guard for all of society and is completely consistent with the core principles that have traditionally underpinned medical practice. A recent published study set out to assess the attitudes of UK doctors concerning active, voluntary euthanasia and physician assisted suicide. The researchers undertook an extensive literature search of English articles published between January 1990 and April 2010. The authors conclude that UK doctors appear to oppose the introduction of active voluntary euthanasia and physician assisted suicide: McCormack R, Clifford M & Conroy M. "Attitudes of UK doctors towards euthanasia and physician-

assisted suicide: A systematic literature review" *Palliative Medicine* 2012; 26(1):23-33 (a copy of which is attached and marked "PAO-2").

Requests for ending life

22. Nevertheless, in the work of a palliative medicine physician, one does encounter patients who request that their life be ended. Sometimes, this request comes in a very specific and explicit form and sometimes it may present in the form of a comment to the effect that "I'd be better off dead". In my experience, all such requests, however vague or explicit, merit further exploration and clarification.
23. In my experience of supervising the care of an estimated 30,000 patients over close on thirty years practice in palliative care, such requests can quite easily be classified into one of three groups as follows:

Group 1 / "I want to die"

24. This is by far the majority of such patients and the statement is used to convey to medical and health care professionals the level of the individual's distress and/or suffering. It is effectively a 'cry for help' and it is the most potent way that the patient has of communicating his/her level of distress to those around them. Once an appropriate response is offered, the request for an early death is typically withdrawn. I have cared for patients who pleaded for physician assisted suicide because they believed that their pain and suffering were intractable. However, in the majority of instances, but not all, once they are offered an optimal level of pain and symptom control in combination with appropriate emotional and spiritual supports the request is quickly withdrawn. The problem of acting on such requests is that there is no going back. One fascinating aspect of the Marie Fleming case in Ireland was an interview given by her daughter to the Irish Times newspaper that was published in May 2013. In this interview, Marie Fleming's daughter recalled that her mother had first raised the possibility of ending her life some ten years earlier because she felt that 'she couldn't go on'. In the interview, Marie's daughter states 'thank God, we managed to change her mind. She would have missed out on so many years and all the younger grandchildren'.

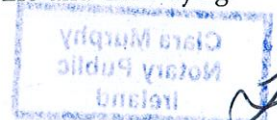


Group 2 / "Let me die"

25. This is a smaller cohort of patients and this request reflects the anxiety and concern that this group has in respect of their own end of life care provision. Typically, this group recognise that their life is coming to a natural end and they are extremely fearful that medical technologies (dialysis, mechanical ventilation, cardio-pulmonary resuscitation etc.) will be applied inappropriately and without regard to the overall benefit/burden of such interventions. Some patients find the prospect of being kept alive by such invasive and intrusive artificial means, particularly in the knowledge that there is no reasonable prospect of achieving any meaningful clinical improvement, utterly abhorrent. Once patients are appropriately reassured regarding the strategies that will be employed at the end of life, the request for an early death is withdrawn.

Group 3 / "Kill me"

26. This group (an important minority) express a clear and consistent wish to exercise the right to have their life ended at a time, in a place and in a manner of their choosing. Typically, these patients are not depressed and they do not ordinarily exhibit features of other mental illness. In contrast, they are commonly quite intelligent, controlling and analytical people who feel the need to continue to exercise the greatest possible level of control over their destiny.
27. This group may be subdivided into two subgroups as follows:
- 27.1 "Kill me now" – this is a very small minority of patients who, after some considerable period of reflection, conclude that they are living a life to no useful purpose and they recognise that there is no reasonable expectation of any clinically significant or meaningful improvement. They are conscious that their life is burdensome to themselves and to those around them and they take a calm and considered decision to seek to have their life ended.
- 27.2 "Kill me later" – this subgroup have also concluded that there is no reasonable expectation of any significant or meaningful improvement in their overall clinical status. On the contrary, they appreciate all too well that they will continue to deteriorate and will experience increasing dependency over time. This group also feel the need to exercise as much control as possible over their life and their dying.



They do not wish to have their life ended immediately but they do reserve the right to make a determination as to when they might wish to have their life ended at some point in the future. Again, the issue of control is vitally important to this group. This was evidently the case for Marie Fleming. In the aforementioned Irish Times interview given by her daughter, she notes that Marie wants to live. This view was echoed by Marie's partner Tom Fleming who stated separately in an interview published in the same edition of the Irish Times in May 2013 that 'Marie doesn't have a death wish. Marie doesn't want to die. She wants to live. She just wants to control the way she dies.'

28. Undoubtedly, there are a significant number of people (both in health and in sickness), who determine that they and/or those around them would be better off if their life ended. In Ireland, we have a serious societal problem because of suicide. Each year, some 500 Irish citizens end their life by suicide. This is a major national issue and much work is underway to seek to reverse the established trends. In this context, it seems contradictory that as a society we should at the same time seek to establish a judicial mechanism to aid and support individuals in the pursuance of their own suicide. In my experience, I have encountered patients who have arrived at this decision in the absence of any evident mental health issues. I have observed and participated in debates regarding active voluntary euthanasia and physician assisted suicide in many countries and over many years. I have concluded that the matter may quite simply be resolved by posing the question:

- 28.1 Do we wish to live as a diverse group of individuals, whose autonomy knows no bounds; or
- 28.2 Do we wish to live in a society in which our rights as autonomous individuals must be tempered on occasions with due regard to the overall societal perspective and wellbeing?

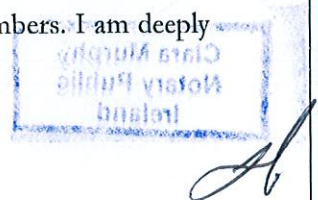
29. If we wish to live as a diverse, independent group of individuals, then the issue of euthanasia is relatively straight forward. In other words, the argument put forward is that the action of one individual has no material bearing on the life or circumstances of another.



30. It is my considered view that the wellbeing of society as a whole is best protected with due regard to the overall wellbeing of society as a whole. Thus, we cannot isolate the effects of individual actions from the impact on the whole of society. Undoubtedly, the testimony of an individual patient who has determined that, notwithstanding all available supports and counselling, they wish to have the right to choose the manner and timing of their death guaranteed in law, is compelling. However, in a societal context, individual rights can only be guaranteed with due regard to their impact on wider society. Thus, in the judgement of the Irish High Court in the much-publicised Fleming case, the judges stated that:

If this court could tailor-make a solution which would suit the needs of Ms Fleming alone without any possible implications for third parties or society at large, there might be a good deal to be said for her case. But the court cannot be so satisfied. Any relaxation of the ban would be inimical to the public interest in protecting the most vulnerable. The risks of abuse are all too real. Even with the most rigorous systems of legislative checks and safeguards, it would be impossible to ensure that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and emotionally vulnerable would not avail of this option to avoid a sense of being a burden to their family and society.

31. Also, if legislation is introduced that confers a right on an individual to have their life ended at a time and in a manner of their choosing, such a right will be utterly meaningless unless there is a corresponding duty of care placed upon others in society to provide this service. This would have an enormously negative impact on the long established role of the physician/doctor in society. It would further significantly undermine the safety and security enjoyed by many people with established and increasing health care needs. This is not best described as a slippery slope argument. Such a potential move is the quintessential paradigm shift. It is my considered view that personal autonomy is not absolute. Rather, personal autonomy must always be balanced with due regard to the overall good of all members of society.
32. Even if we accept that a competent autonomous individual has the right to request physician assisted suicide, how can one be certain that such a request is not made under some form of duress, explicit or implicit? I am aware from my work with many elderly people of the real concern they have regarding the burden that their on-going care presents to close family members. I am deeply



concerned that such vulnerable groups, were physician assisted suicide made legal, might request such a course, in order to spare their loved ones the burden (financial and emotional) of providing their on-going care. Even more concerning is my suspicion that such patients may never acknowledge such a motive.

33. The situation becomes exponentially more complex when it is applied in respect of patients with impaired cognitive function. Competence is a difficult entity to accurately measure and establish. It may frequently be a fluctuating phenomenon. If a person has lost competence, who then should be empowered to make a decision of their behalf regarding physician assisted suicide? In such circumstances, how can one be certain that all involved parties will act totally and exclusively in the best interest of the individual patient and will not be influenced by other external factors? The situation would clearly be quite impossible.
34. As mentioned earlier, the beauty and benefit of the current legislative position is that it is abundantly clear and absolutely explicit.

Palliative sedation

35. I am asked to comment on the issue of palliative sedation. Palliative sedation in the context of palliative medicine is defined by the European Association for Palliative Care as the:

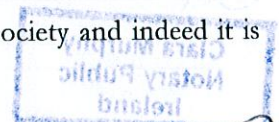
...monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and health care providers.

36. Sedation is used in palliative care in several settings including:
 - 36.1 Transient sedation for noxious procedures;
 - 36.2 Sedation as part of burn care;
 - 36.3 Sedation used in end of life weaning from ventilator support;
 - 36.4 Sedation in the management of refractory symptoms at the end of life;
 - 36.5 Emergency sedation;

36.6 Respite sedation; and

36.7 Sedation for psychological or existential suffering.

37. The European Association for Palliative Care consider sedation to be an important and necessary therapy in the care of selected palliative care patients with otherwise refractory distress. Prudent application of this approach requires due caution and good clinical practice: Cherny, NI, Radbruch, L, & the Board of the European Association for Palliative Care. "European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care" *Palliative Medicine* 2009; 23(7):581-593 (a copy of which is annexed and marked "PAO-3").
38. In my experience, palliative sedation in Ireland is used with great care and consideration. It is a therapeutic approach of last resort and requires very careful patient selection, monitoring and supervision. As in all areas of therapeutics, the objective is to achieve the desired result with the minimum dose of medication and with minimal adverse effects. This strategy is applicable when employing all medical therapies.
39. It is important to recognise that palliative sedation is typically employed to ease the distress and suffering of an individual patient at a time when they are actively dying, as a direct, unavoidable and inevitable consequence of the underlying disease process. In other words, these patients are going to die, with or without palliative sedation. However, they will die much more peacefully and in much less distress if their symptoms and distress are appropriately managed. Clearly, the juxtaposition of these two events (i.e. the fact that the patient is dying and the judicious use of sedative medication) does not imply and should not be represented as existing in a cause and effect relationship. In other words, the level of sedative medication is carefully titrated to ease the patient's distress but is not administered in such doses whereby the clear intention is to shorten a person's life.
40. It is worth noting that sedative medications are not always utilised with the intention of inducing sedation *per se*. They may be utilised to enable a highly anxious individual function in a stressful situation. I am aware that sedative medications are used very widely across all sectors of society and indeed it is



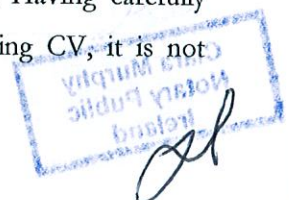
reported that 10% of medical card holders in Ireland are currently using benzodiazepine preparations.

41. In the palliative care setting, palliative sedation is an important and necessary therapy that is employed judiciously in carefully selected and supervised patients. One such example is the case of the patient who develops a catastrophic haemorrhage that will inevitably result in the death of that patient. In such circumstances, sedative medication would and should be employed to reduce the burden of this appalling occurrence on the individual patient.
42. In summary, palliative sedation is an important and necessary therapy in the care of selected patients with otherwise refractory distress. In terms of establishing a problem as refractory, it is assumed that the individual has engaged meaningfully with clinicians with the necessary training and competencies to manage the most challenging and difficult scenarios. A problem that a non-specialist may regard as refractory may be quite routine, even mundane to a specialist provider. Palliative sedation is not intended to hasten death and it is not and should not be represented a sanitised version of physician assisted suicide. In this population, these patients are dying from the inevitable, unavoidable and irreversible consequences of advanced and progressive disease and palliative sedation is used solely and exclusively to offer them an enhanced level of comfort and reduced symptom burden. Its use should be restricted to circumstances where patients continue to suffer extreme distress that is refractory to all other therapeutic approaches. It should only be initiated following assessment by an appropriately competent and experienced clinician.

Evidence of Dr Rajesh Munglani

43. I have been provided with a copy of the affidavit sworn by Dr Rajesh Munglani dated 22 April 2015. In the following paragraphs, I set out my comments on that affidavit.

- 43.1 I note that Dr Munglani is a consultant in pain medicine practicing in the United Kingdom. Amongst other matters, Dr Munglani in his affidavit undertakes to provide evidence concerning the role of consultants in pain medicine in end of life care. Having carefully reviewed Dr Munglani's affidavit and accompanying CV, it is not




clear to me the extent of Dr Munglani's involvement with patients in end of life situations. Having sought additional information on Dr Munglani's website (www.rajeshmunglani.com), I am advised that *'the main interest of Dr Munglani's pain clinic is chronic spinal pain ... the majority of patients come with persistent back pain, whiplash injury or complex regional pain syndromes'*.

43.2 I note that none of the publications listed in his CV are devoted exclusively to cancer pain management. Dr Munglani does append to his affidavit a copy of an article that he co-authored on the subject of 'Pain and suffering in cancer patients.' This paper was not published in a mainstream, peer-reviewed medical publication but in a title called 'Modern Believing' which I understand is the journal of Modern Church. The website for Modern Church describes the publication as devoted to articles on *'theology and related disciplines to promote theological liberalism'*.

43.3 Dr Munglani records that he 'still sees patients in severe distress; they are often over-medicated and confused following quite natural attempts to control their symptoms, and they continue to suffer with little or no quality of life'. Dr Munglani suggests that he might see such patients at least twice a year. The reviewer is not advised of the total number of patients seen by Dr Munglani in a typical year, but a reasonable interpretation of the data presented in the affidavit suggests that this is a relatively infrequent occurrence. Again, the reviewer is left to speculate as to whether these twice yearly occurrences arise in the context of cancer pain or non-cancer pain. I am puzzled and surprised by the observation that there are a number of patients who cannot be helped without 'heavy sedation', particularly in the context where 'dying does not appear to be imminent'. This is at variance with my practice. I do not understand or recognise the concept of 'long term sedation to the point of unconsciousness' and indeed this again runs contrary to the whole focus of palliative care which is to improve quality of life. The EAPC guidelines on the use of sedation in palliative care are quite explicit in this regard: 'continuous deep sedation should only be considered if


Clara Murphy
Notary Public
Ireland


Clara Murphy
Notary Public
Ireland

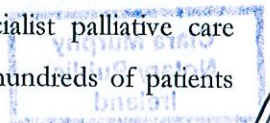
the patient is in the very terminal stages of their illness with an expected prognosis of hours or days at most': Cherny NI and Radbruch L, *op cit*, annexed as "PAO-3". Thus, there is no circumstance where one would wish to use 'heavy sedation' in circumstances other than when death is imminent.

43.4 Dr Munglani furnishes the reviewer with a lengthy but unbalanced list of complications associated with the use of opioids, steroids and other medications. This element of Dr Munglani's evidence is particularly unbalanced and fails to address the unique benefits associated with the careful, supervised and judicious use of such agents. All medications and therapies have the potential to cause adverse effects. The skilled clinician will ensure that the benefits associated with the use of all such medications will outweigh any adverse effects. The astute clinician will not persist with a therapy which has the net effect of increasing the burden for patients. The WHO has endorsed the judicious use of opioids as the mainstay of our approach to cancer pain management since 1986. This view is echoed by interested bodies such as the European Association for Palliative Care, the International Association for the Study of Pain and the British Pain Society. Of course, all medicines are capable of causing harm and due care must be exercised at all times. The Single Convention on the use of Narcotic Drugs 1961 (amended 1972) noted that the medical use of narcotic drugs continues to be indispensable for the relief of pain. The president of the International Narcotics Control Board wrote in 2011 that policy makers '...should devise and implement enabling policies that promote widespread understanding about the therapeutic usefulness of controlled substances and their rational use'.

43.5 In Dr Munglani's final paragraph, he concludes that if the option of assisted suicide is denied, the options thereafter rest between unbearable pain, sedation or death by committing suicide. I find this degree of catastrophisation to be entirely fanciful and it does not in any way reflect the reality of a modern specialist palliative care programme. I have personally cared for many hundreds of patients



Clara Murphy
Notary Public
Ireland




with primary and secondary brain tumours and in my extensive experience, the types of scenarios envisaged and represented are rarely if ever encountered. I respectfully suggest that the provision of high-quality, patient-centred specialist palliative care is a preferable option when compared to unbearable pain, suicide or deep sedation.

Affidavit of Michael Ashby

44. I make the following observations on the affidavit of Michael Ashby.

44.1 As to paragraphs 14 to 17, I do not agree with the simplistic view that patients request physician assisted suicide as a means of avoiding pain. In my experience that is simply not true. The reasons people seek PAS are wanting to control circumstances of death, fear of poor quality of life in the future, loss of independence in the future, loss of dignity and fear of inability to self care. Pain typically ranks quite low: Ganzini L, Goy ER, Dobscha SK. "Why Oregon patients request assisted death: family members' views." *J Gen Intern Med* 2008; 23(2):154-157 (a copy of which is annexed and marked "PAO-4").

44.2 As to paragraph 23, I note the common scenario of catastrophisation. Increasing dependence and impaired mobility are not necessarily incompatible with quality of life. Take a look at Stephen Hawking and countless others, such as Jean-Dominique Bauby who authored *The Diving Bell and the Butterfly* while experiencing "locked-in" syndrome.

44.3 As to paragraph 28 I note (and concur) with Professor Ashby's view that pain is not a dominant or intractable feature in patients with glial tumours.

SWORN

at Cork this

6th day of
May 2015

before me:

Clara Murphy

)
)
)
)

Patrick Anthony O'Brien

Patrick Anthony O'Brien

A person authorised to administer oaths by the law of Ireland

Clara Murphy
Notary Public
Ireland

