

I, Judith Lynne Pickthorne, of Wellington, swear:

1. I am a Palliative Care Nurse Specialist at Wellington Hospital.
2. I have been working in the area of Specialist Palliative Care for the past 13 years, particularly within the acute sector. My prior nursing background has included respiratory medicine, medical oncology, chemotherapy administration and district nursing.
3. A copy of my curriculum vitae is attached as exhibit "JLP-1".
4. I am the Chair of Palliative Care Nurses New Zealand Society Incorporated, a non-profit organisation founded in 2006 that currently represents 183 nurses from all care settings who either work or have an interest in the speciality of Palliative Care.
5. I make this affidavit on behalf of Palliative Care Nurses NZ. To the extent that I am also giving expert evidence, 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.
6. Palliative Care Nurses NZ's kaupapa, *Tauārai o te pō, tītoki o te ao mārama*, is a Maori saying which is applied to those who offer protection to people at risk. We believe that the deliberate, pre-meditated act of ending someone's life is against the caring philosophy of nursing and palliative care.
7. Palliative Care Nurses NZ has a position statement on euthanasia and assisted dying, approved in September 2012. We are opposed to assisted dying in any form. Our position statement states:

PCNNZ, as a professional nursing group, believes assisted dying in any form is incongruent with the underlying ethos and practice of palliative care nursing.

PCNNZ advocate that:

- Palliative care should be routinely available to all who need it, and Government should prioritise and ensure that public funding is made available to increase the availability of palliative care, whether provided by hospital, at home (by the primary health team), in residential aged care facilities or hospices.



- All patients should be made aware of the options for hospice and palliative care, and should be offered individual assessment of their needs to ensure that appropriate palliative care is being provided.


- PCNNZ supports the position of the Australia & New Zealand Society of Palliative Medicine (ANZSPM) who advocate that the focus should be on excellence in hospice and palliative care and not euthanasia or assisted dying.

- PCNNZ advocates education opportunities be available for all nurses and other health professionals to acquire necessary knowledge and skills in the principles and practice of palliative care, fostering compassionate and comprehensive end of life care in all health settings.

8. Caring for those at the end of life requires attending to all aspects of a person, not just the physical but also the emotional, spiritual and psychosocial. This can also be understood in the Māori approach to health and wellbeing of Te Whare Tapa Whā (four sided house): Te Taha Tinana (physical health), Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health) and Te Taha Whānau (family health).
9. Working within a specialist palliative care role we are often providing care across a range of care settings including hospital, aged residential care and in peoples own homes. Many of us will be working autonomously and of all the health care professionals involved, nurses will often have the most contact with the person. We are also most closely involved in their day to day care, monitoring their comfort and assessing and evaluating the management of their symptoms and medications. We offer and provide support to their whanau.
10. We are conscious of the tremendous privilege we are given to accompany each person and their family on their unique journey. It is simultaneously a draining and exhilarating role because it can only be done well by being emotionally engaged. We do this because we believe deeply in the dignity of each and every individual and their right to live well all the way to the end.
11. We know the reality of what people face as they go through this process. We know that good palliative care makes a difference, not just through our specialist technical expertise and skills, but often more importantly by the nature of the care we provide.



12. In my experience, many if not most people (and their families) are scared and frightened as they first engage with palliative care. A key part of our role is to address their fears and concerns by talking openly about what lies ahead. As they learn about what to expect and what can be done to assure them of their dignity and comfort throughout, their fears are lessened. They can then turn their focus to the really important things they want to accomplish in the time left to them. Naturally, most often that is their relationships with family and friends.
13. Physician assisted suicide and euthanasia would be entirely inconsistent with what we do in palliative care. We care for people, and the whole ethic of our care is to help people live every moment they have left, with hope, that life is a gift that it still has value right to the end. We work hard to install and nurture hope in the people we care for. We work hard to ensure that our patients trust us to be always caring for them, and that they will not be abandoned.
14. The mind set of assisted suicide and euthanasia is the complete opposite of that. It is saying that there is no hope of anything good to come, that their life has no value and is not worth living, and that the care we offer is not going to help them.
15. We couldn't stand in two camps: in the one hand holding care and hope, in the other killing and despair. I could not practice in this environment – I can't conceive of being able to move from one patient to another, knowing that I had been instrumental in deliberately causing the death of one and then trying to care for the next through whatever challenges they are facing that day.
16. Professional nursing practice must be lawful *and* ethical. A law change that conflicted with our duty to act ethically would tear at the fabric of the profession. People who did not want to be implicated in euthanasia and assisted suicide would slowly but surely leave the profession, or never join in the first place. Eventually the profession would be characterised by people who had decided that euthanasia and assisted suicide is somehow compatible with palliative care. That would be a very different palliative care than I understand and practice.

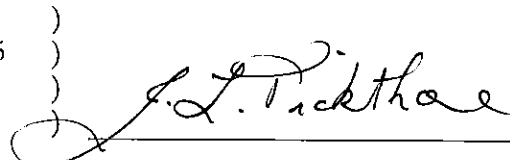


17. We are also concerned with the risks that assisted suicide and euthanasia would bring to people under our care. Our association includes many who work in aged care facilities and in the community, and we are aware of how vulnerable the elderly and frail can be. There is a real susceptibility to feeling that they are a burden, which could place real pressure on people to opt for an early death because they see that is the right thing to do for their families. Coercion and pressure from families can happen, and not even necessarily in a bad or ill-intentioned way: it can be hard for families to see a parent dwindle and become unwell, and we see situations where the family is more distressed at what is happening than the person themselves, who may be accepting of where they are at and looking to live their life as well as they can manage.
18. We are also concerned that once assisted dying was in the community there would be subtle pressures operating on people to 'do the right thing' and people might feel that they had no right to be alive once they started needing a higher level of care. There is also a risk that people will make decisions when they are poorly informed of the care options for them: a great deal of misinformation and myths surround palliative care, and sometimes it is only when people engage with us that they come to understand what can be done for them.
19. I would also be concerned that some people would not engage with palliative care at all because they didn't trust us not to kill them. This was an early misconception about the hospices, and it would not be difficult to see it coming back again. People who need and would benefit from our services would suffer unnecessarily.

SWORN

at Wellington this 11th day of May 2015

before me:


 Judith Lynne Pickthorne


 Joyce Velasco

A (Deputy) Registrar of the High Court of New Zealand