# Palliative Care, Double Effect and the Law in Australia

## Introduction

The application of the doctrine of double effect to the provision of palliative care has been the subject of consideration from ethical and clinical perspectives (1-7). However, very little has been written about the extent to which the doctrine actually provides legal protection for doctors in Australia. This is significant because the scope of the legal defence is not settled. Further, ongoing legislative intervention in this area, enacted with the public policy intent of improving care at the end of life by clarifying the law and protecting practitioners who deliver appropriate palliative care, has changed the nature of the defence in some Australian States and this new statutory model may be adopted in other parts of the country. Although the only prosecutions in this area of practice hitherto have been where causation of death and the health care worker's intention were both clearly in question, this article considers the extent to which doctors can rely on the doctrine of double effect when providing palliative care, the nature of current and likely future legislative reform and the implications these developments have for clinical practice.

## Discussion

In an examination of the medical, legislative, judicial and parliamentary scrutiny of end of life issues in Australia between 1983-1998, and in four comparable OECD countries: the United Kingdom, Canada, USA and New Zealand, it can be shown that all the reports, legislation, judgments and parliamentary committee proceedings studied

assume that palliative care interventions and treatment abatement decisions may indeed constitute a cause of death. However, this is allowed in law due to the public policy imperative to relieve pain and suffering and avoid prolongation of the dying process (8).

Ethics, public policy and the law have all given strong support to the need to control pain, retain dignity and avoid futile and burdensome treatment for people who are dying, provided that death is not ***intentionally*** caused in the process. The so-called principle, rule or doctrine of double effect, derived from the tradition of Catholic moral theology, offers a bioethical technique that can be used to make a distinction between lawful palliative care interventions and euthanasia (in jurisdictions, such as presently all those in Australia, where this is illegal).

*The doctrine of double effect*

The essence of the doctrine of double effect is that an act performed with good intent can still be moral despite negative side effects. In the context of palliative care, this can arise when four conditions are met (1, 3):

1. Administering palliative medication is not, in itself, immoral;
2. The intention is to relieve pain, not to hasten the patient's death;
3. The relief of pain is not achieved through causing the patient's death; and
4. Proportionally, the need to relieve pain is such that it warrants accepting the risk of hastening death.

The doctrine, applied to palliative care, is generally accepted in the medical profession and its peak bodies (2, 9-10) although some dispute its relevance on the basis that

properly administered palliative care does not hasten death (6). It has, however, been subjected to trenchant criticism in this role by philosophers (11-13), lawyers (14) and clinicians (15-16).

There is no tradition of double effect being used in legal reasoning until it was adopted by the common law in end of life treatment decisions. It first appears as the basis of the 1957 instruction to the jury by Devlin J (as he then was) in *R v Adams* (17-18), in the specific situation of the use of opioid drugs, for pain relief in end of life care:

> But that does not mean that a doctor who is aiding the sick and the dying has to calculate in minutes or even hours, and perhaps not in days or weeks, the effect on the patient's life of the medicines that he administers or else be in peril of a charge of murder. If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life. This is not because there is a special defence for medical men but because no act is murder which does not cause death. We are not dealing here with the philosophical or technical cause, but with the commonsense cause. The cause of death is the illness or injury, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term. But ... no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life.

The judgment is based on the medical evidence submitted to the court that reflected the medical view of the time that because morphine can cause respiratory depression, its use in pain and symptom relief can lead to coma and death. In particular, the notion that there is agreement about a 'high' dose of an opioid drug such as morphine beyond which timing and possibly causation might be in question has permeated medicine, and hence, every legal deliberation on this issue since.

However, the experience of the hospice and palliative care movement over the past three decades has shown that the safe and effective use of morphine, other opioids, and sedatives in pain and symptom control need not bring cause of death into question (19).

There is no clinical scientific evidence that morphine causes death, if used with appropriate skill to treat symptoms. In particular, the respiratory depressant effects have been shown to be minimal, and it seems that the presence of pain acts as antagonist to respiratory depression and sedative effects of opioids (20). However, like any class of drugs, the opioids are dangerous if used inappropriately.

The Ontario coroner (Dr James Young) laid down four conditions that need to be satisfied for palliative care interventions to be legal in his jurisdiction. These conditions describe well the clinical and ethical basis of palliative medicine practice internationally, and would have wide support in the specialty for differentiating it from euthanasia:

> (1) The care must be intended solely to relieve suffering; (2) it must be administered in response to suffering or signs of suffering; (3) it must [be] commensurate with that suffering; and (4) it cannot be a deliberate infliction of death. Documentation is required, and the doses must increase progressively. (21-22)

The intention is to relieve symptoms and suffering, not bring forward the time of death. Whilst this position is sustainable in the palliative phase, it is susceptible to challenge in the terminal phase, when death is imminent (hours or days away) (23). It should be acknowledged by practitioners that, as death approaches, abatement of life-sustaining treatment and terminal sedation may indeed alter the time of death, although this matter cannot be verified scientifically, one way or the other, in a particular case, or in general. There are serious limitations to the use of clinical studies in this area, and the causal question itself cannot be directly asked in any interventional study for obvious reasons. We cannot know when a particular patient would have died in the absence of palliative interventions or treatment abatement, particularly during the final dying process, and it would be unethical to design randomised controlled trials to find out. However, two clinical observational studies show no evidence of shortened survival resulting from opioid or sedative use in the last days of life (24-25).

*Potential criminal responsibility for palliative care*

The law seeks to avoid criminalising appropriate medical practice. When considering such matters, the law usually appears to take a common sense and multifactorial view of causation, and will often not even apply a causal analysis, focusing more on legality of actions and presence or absence of duties instead (26)

However, causing or hastening a person's death can give rise to criminal responsibility. The offence that is most likely to arise is murder. This is proven where a person's death has been caused (or accelerated) by another and where there is an intention to kill (27). Although there is some variation in different Australia jurisdictions, of significance is that the criminal law generally regards foreseeing death as a probable consequence of acting as sufficient to constitute intent. It is in the context of this potential criminal liability when providing palliative care that the doctrine of double effect has received some limited consideration by the courts (see below).

*Recognition of the doctrine at law*

The elements of the common law defence are outlined in more detail below. However, in brief, the doctrine of double effect provides a defence to a criminal charge where it is alleged that a doctor has caused the death of a patient as a result of the provision of medication if the intention of the doctor in providing that medication was to relieve pain rather than to hasten the patient's death. There has not been a case that has considered whether the doctrine of double effect is part of Australia's common law. But the doctrine has received some judicial endorsement in similar legal systems such as the United Kingdom (17, 28-30), the United States (31-32), Canada (33) and New Zealand (34-35) and is likely to be accepted as part of the common law of Australia (36). The

status of the common law doctrine of double effect is less clear in the Northern Territory, Queensland, Tasmania and Western Australia, where the criminal law has been codified so that criminal responsibility is determined on the basis of the various *Criminal Codes*.

There are competing arguments as to the basis for legal recognition of double effect (37-38), but the most widely accepted formulation of the doctrine at law is based on a doctor's *intention*. If the primary intention of the person administering palliative care is to relieve pain, and not cause death, then that person will not be criminally responsible for a death that might follow, even if it is foreseen. The legal operation of the doctrine of double effect is illustrated by two famous cases: *Adams* and *Cox* (see Box 1 below).

In three States, legislation has created different defences which are generally more limited than the doctrine of double effect. Queensland and Western Australia have sections 282A and 259 respectively in their *Criminal Codes*. South Australia has stand alone legislation, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA), section 17 of which creates a defence for palliative care in certain circumstances. These provisions are set out in Box 2 below. The need for legislative action was more pressing in Queensland and Western Australia given that their criminal law had been codified. South Australia is in the unique position of having a legislative defence and perhaps also the possibility that the doctrine of double effect at common law continues to exist in that State. The South Australian legislation also expressly distinguishes accepted palliative care practice from euthanasia, whereby the former is deemed not to introduce a 'novus actus interveniens' in a pre-existing chain of causation. Causation was

specifically addressed for political reasons, to ensure the Act's passage through parliament, where certain key members of parliament were concerned about euthanasia 'by the back door', but also because the relevant parliamentary select committee was very keen to protect practitioners from fear of legal sanction so that the Act's objectives could be fully met (39).

*Scope of legal protection*

There are four major issues that determine the scope of legal protection provided by the doctrine of double effect or the legislative defences: a doctor's intention, the standard of medical care required, whether consent is needed, and the relevance of a patient's condition.

***A doctor's intention:*** Under the common law and statutory defences, a doctor cannot have an intention to cause death. In all States except Western Australia, the law also expressly requires that the intention instead be to relieve pain and suffering.

***Medical practice standards required:*** Under the common law, there is no requirement to comply with particular medical standards. However, departures from reasonable medical practice may suggest an intention to kill rather than to relieve pain. It is also unlikely that the common law doctrine would protect a doctor who gave palliative medication at such high doses as to be grossly negligent.

The position appears stricter in Queensland and Western Australia. In Queensland, the palliative care must be reasonable in the context of good medical practice taking into

account the patient's state and all circumstances. 'Good medical practice' is defined to mean good medical practice nationally having regard to recognised medical standards, practices and procedures and ethical standards of the medical profession in Australia. The Western Australian defence does not make reference to medical standards but does require that the treatment be 'reasonable, having regard to the patient's state at the time and to all the circumstances of the case'. Under the South Australian legislative defence, the medical treatment must be provided 'in accordance with proper professional standards of palliative care'.

***Consent:*** Consent from the patient or a person authorised to consent on their behalf is not required by the doctrine of double effect at common law. Consent is also not mandated in Queensland or Western Australia but may be relevant to assessing whether the treatment is 'reasonable'. This is particularly so in Queensland where reasonableness is judged in the context of good medical practice. Because treating without consent is generally unlawful, it may be difficult to argue that good medical practice accepts unlawful conduct, particularly if it hastens death. The South Australian legislative defence expressly requires consent from the patient or from a person empowered by law to consent of their behalf.

***Relevance of a patient's condition:*** It is likely that the common law doctrine will only apply to a patient who is near death. This has been the state of the patients in the cases that have come before the courts to date (although in one case later investigations revealed that the doctor's belief as to the patient's condition was mistaken) (40). Although the courts have not expressly limited the doctrine's operation in this way, the

better the patient's prognosis, the less likely the doctrine is to protect doctors if death is hastened.

Queensland and Western Australia also do not expressly require a patient to be near death. However, as with the issue of consent above, the need for treatment to be regarded as reasonable may preclude protection in cases where a patient's prognosis is not poor. Western Australia also requires that the treatment be for the benefit of a patient, which again will be difficult to demonstrate in circumstances where death is not approaching. The cause of that approaching death need not, however, be a terminal illness or even a medical condition. It was recently accepted that the Western Australian provision will apply in circumstances where the need for palliation arises due to a refusal of life-sustaining treatment (41).

The legislative defence in South Australia only applies where a patient is in the 'terminal phase' of a 'terminal illness'. This occurs when a patient is suffering an illness or condition that is likely to result in death and there is no real prospect of recovery or remission of symptoms, either temporarily or permanently.

**Conclusion**

While the common law is largely consistent with the doctrine of double effect as an ethical principle, this is not the situation for the legislative excuses. These defences are of a different nature, particularly in relation to the required standard of medical care and consent.

The most significant change is the legislative requirement to adhere to a particular standard of medical practice. Generally, criminal responsibility for careless medical practice is imposed only where the conduct of the doctor is so grossly negligent that it should be regarded as a crime against the State and therefore worthy of punishment. By contrast, the legislative defences to criminal charges in Queensland and South Australia are available only if a higher standard is met: doctors must comply with good medical practice or proper professional standards of palliative care respectively.

This is significant not only because a higher standard of practice is required but also because legal exposure for doctors is increased by making criminal acts less challenging to prove. At common law, the focus is on a doctor's subjective intention. This is notoriously difficult to establish (2-4, 7, 42), particularly beyond reasonable doubt as is required in the criminal law setting. Fewer difficulties arise in proving a failure to comply with an objective and measurable standard of practice. The probable outcome is that the State, when prosecuting a doctor, is likely to focus on demonstrating that the standard of care was inadequate, as that is easier to prove than criminal intent.

In relation to consent, the legislative defences again offer less protection than at common law. Whereas consent from a patient or someone authorised to consent on his or her behalf is not required under the common law defence, it is if relying on the South Australian legislation and possibly also in Queensland and Western Australia. The effect is that a doctor could potentially be subject to criminal liability for unlawfully causing death due to a failure to obtain consent for otherwise appropriate palliative care.

While this may be less problematic in South Australia if the defence at common law is also available, this is of concern in Queensland and Western Australia where the legislative provisions provide the sole defence.

The nature of medical decision-making at the end of life gives rise to legal risk (42). Although criminal prosecutions are rare, interaction with the legal system can have significant consequences for those involved, even if their actions are vindicated (42-43). It is therefore vital that doctors are aware of these local legislative changes, particularly in Queensland and Western Australia where the defence is the only one available. Legal obligations in these jurisdictions will not be satisfied simply by acting in accordance with what the doctrine dictates as an ethical principle. Recent Western Australian case law makes clear that, at least in that State, protection depends on the terms of the legislative defence and not double effect (41).

Further, we anticipate these issues will, in due course, become significant nationally. A modified version of the doctrine of double effect has been given legislative force in three of the eight Australian jurisdictions and this trend to legislate is likely to continue. Despite the likelihood that the doctrine forms part of the common law in Australia, it does not sit comfortably with fundamental criminal law principles relating to intention and causation of death (37-38). For example, in relation to intention, the criminal law usually imposes liability not only where a person acts intending to achieve an outcome but also where that outcome is foreseen as probable (37). Such an approach is problematic for double effect as it depends on foreseeing, but not intending, an outcome. The position in Code jurisdictions is also troubling as there are doubts about

whether the common law doctrine could be relied upon. Legislative action is a logical solution to address concerns about criminal liability conclusively (37-38) and this is likely to be seen as an attractive option for Governments, particularly in States where criminal law is codified. If the major features of the current legislative models are adopted elsewhere in Australia, securing the legal protection provided by the legislation when administering palliative care will require consideration not only of intention but also medical practice standards and obtaining consent.

It is important to note, however, that practising palliative medicine appropriately should not give rise to criminal liability. Whether it be the common law or legislative defences that are relied upon, acting in accordance with good medical practice, which includes an appropriate intent and obtaining the requisite consent, is sanctioned by law. It is essential that law and public policy continue to support the relief of suffering at the end of life, so that health care workers and families of dying people can ensure that care and decisions at the end of life are unhindered by false perceptions of what the law may say. Regardless of future legislative changes that may legalise euthanasia, it will still be necessary to differentiate it from palliative care, and be transparent with regard to intention and goals of care.

**Box 1: Key cases on double effect at common law**

*R v Adams* (1957, United Kingdom) (17)

Dr Adams was a general practitioner charged with the murder of an 81 year old patient, Mrs Morrell. It is unclear from the case report the precise medication administered in the period leading up to Morrell's death but it included morphine and heroin as well as two 'large' injections of paraldehyde on the night before she died. Prosecutors argued that Morrell was in a coma in the last days of her life and called two medical experts who concluded that there was no medical justification for this level of palliation. The quantities and combination of the drugs demonstrated an intention to kill. The defence's medical expert disagreed and did not consider the medication of Morrell to be excessive in the circumstances. Doubt was also cast on the evidence that Morrell was in a coma and so it was argued that pain relief was needed. The jury acquitted Adams. Although the basis of the verdict is not known, it has been subsequently argued that the jury must not have been satisfied beyond reasonable doubt that Adams intended to kill Morrell rather than relieve her pain.

*R v Cox* (1992, United Kingdom) (28)

Dr Cox was a rheumatologist charged with the attempted murder of Mrs Boyes, an elderly patient suffering from rheumatoid arthritis. Cox was not charged with murder because it was not possible to exclude that Boyes' other conditions caused her death. The evidence revealed that the doctor and patient relationship over 13 years had led to an unusually strong bond of affection and mutual respect between them. As Boyes deteriorated, Cox became unable to manage her pain. He then administered 26 millimoles of undiluted potassium chloride, which was described as having no curative or analgesic properties and was estimated to be twice the lethal dose. Boyes died within

minutes. The jury was instructed to convict Cox if satisfied that his primary intention in administering the potassium chloride was to cause Boyes' death. The judge noted that although the administration of medication with the purpose of relieving pain and suffering can be lawful, this relief cannot be achieved through intentionally causing another's death. Cox was found guilty by the jury but received only a one year suspended sentence.

**Box 2: Legislative defences**

**Sections 17 and 18 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA)**

**17—The care of people who are dying**

(1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress—

(a) with the consent of the patient or the patient's representative; and

(b) in good faith and without negligence; and

(c) in accordance with proper professional standards of palliative care,

even though an incidental effect of the treatment is to hasten the death of the patient.

...

(3) For the purposes of the law of the State—

(a) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause[1] of death;

...

**Note—**

1 A novus actus interveniens ie a cause that breaks a pre-existing chain of causation.

**18—Saving provision**

(1) This Act does not authorise the administration of medical treatment for the purpose of causing the death of the person to whom the treatment is administered.

(2) This Act does not authorise a person to assist the suicide of another.

**Section 259(1) of the *Criminal Code* (WA)**

**259. Surgical and medical treatment**

(1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) —

(a) to another person for that other person's benefit; or

(b) to an unborn child for the preservation of the mother's life,

if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

## Section 282A of the *Criminal Code* (Qld)

**282A Palliative care**

(1) A person is not criminally responsible for providing palliative care to another person if—

(a) the person provides the palliative care in good faith and with reasonable care and skill; and

(b) the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and

(c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing.

(2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person's death.

(3) However, nothing in this section authorises, justifies or excuses—

(a) an act done or omission made with intent to kill another person; or

(b) aiding another person to kill himself or herself.

(4) To remove any doubt, it is declared that the provision of the palliative care is reasonable only if it is reasonable in the context of good medical practice.

(5) In this section—

***good medical practice*** means good medical practice for the medical profession in Australia having regard to—

(a) the recognised medical standards, practices and procedures of the medical profession in Australia; and

(b) the recognised ethical standards of the medical profession in Australia.

> ***palliative care*** means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.

It is also noted that the Australian Capital Territory has a reference to pain relief in section 17 of its *Medical Treatment (Health Directions) Act 2006* (ACT). This provision is not considered separately in this article because we do not consider it alters the common law position. There is no reference to removing criminal liability; the section simply states that a patient has a 'right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances'. The provision also has a very limited scope, operating only where there is a health direction (advance directive) made under the Act that refuses medical treatment.

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