The Doctrine of Double Effect and Potential Criminal Liability of Medical Practitioners in Australia

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Recent parliamentary inquiries into end-of-life choices identify the need to provide legal certainty for health practitioners working in end-of-life care. A concern identified is the lack of clarity surrounding the operation, status and application of the doctrine of double effect. This discussion clarifies these concerns. Although the doctrine is judicially recognised in several overseas jurisdictions, in Australia the doctrine of precedent means that it does not form part of the common law. In most jurisdictions, the fault element for murder includes recklessness, and application of the doctrine does not avoid criminal liability being established against orthodox criminal law principles. Although the prosecution of a medical practitioner who incidentally causes death in the proper course of medical treatment is a rare event, it remains a live issue. Legislative protection of medical practitioners, as has occurred in Queensland, South Australia and Western Australia, is the means to achieve the certainty sought.

Keywords: ***medical treatment; palliative care; end of life care; doctrine of double effect; double effect reasoning; murder; recklessness; criminal liability***

INTRODUCTION

In 2015, the Victorian Legislative Council's Standing Committee on Legal and Social Issues undertook a comprehensive inquiry into the need for laws in Victoria to allow citizens to make informed decisions about their end-of-life choices (Victorian Inquiry). Subsequently, in Western Australia the Joint Select Committee of the Legislative Council on End of Life Choices undertook a similar inquiry (Western Australian Inquiry). The respective terms of reference included an assessment of the role of palliative care.[1] An issue identified is the lack of clarity surrounding the operation, status and application of the doctrine of double effect.[2]

In the course of the Victorian Inquiry a number of submissions flagged "[t]he need to provide legal certainty for health practitioners working in end of life care".[3] The Final Report identifies that "[t]he Committee heard that uncertainty about the law leads health practitioners to fear prosecution, [and that] a fear of prosecution amongst medical practitioners may make them hesitant to provide pain management that could have a secondary effect of shortening life".[4] In the course of the Western

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[1] Legislative Council Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices Final Report* (2016) xiii (*Victorian Report*); Legislative Assembly Joint Select Committee on End of Life Choices, Parliament of Western Australia, *Report 1: My Life, My Choice* (2018) 231 (*Western Australian Report*).

[2] *Victorian Report*, n 1, 110; *Western Australian Report*, n 1, 135.

[3] *Victorian Report*, n 1, 110.

[4] *Victorian Report*, n 1, 111.

Australian Inquiry medical professionals identified an identical concern.[5] The inquiries led to the *Voluntary Assisted Dying Act 2017* (Vic) and the *Voluntary Assisted Dying Act 2019* (WA), which is expected to come into force in mid-2021.

The Victorian Act allows a person who is enduring suffering that has become intolerable to them to make the decision to access voluntary assisted dying. Within the Act there are strong safeguards in place to ensure the decision to hasten their impending death "is the person's own, and that it is voluntary, informed and enduring".[6] The reason for these strong safeguards is because the Act crosses the "Rubicon" between an act of omission – to withhold treatment and allow a patient to die – and an act of commission – to kill a patient.[7] The supervision and control surrounding such legalised killing contemplated by the Act in Victoria is significant.[8] The Act does not, however, clarify the legal position of medical practitioners involved in palliative care or the operation of the doctrine of double effect. In this regard, the Australian Medical Association (Victoria) Ltd in its submission to the Victorian Inquiry observed that:

> In Australia there is no case law directly on point relating to the double effect doctrine. Although some legal commentators argue that there seems little doubt that the double effect principle at common law forms part of the Australian Law due to its acceptance in other jurisdictions, the legal recognition has been widely criticised as being inconsistent with criminal law principles. Medical practitioners who follow current best practice by providing whatever care is needed to alleviate pain and distress cannot be confident that they would be protected from criminal law prosecution for murder, manslaughter or aiding or abetting suicide.[9]

To cause the death of another person is a morally grave action. The principle of double effect holds that under certain conditions it is morally permissible to do so provided that causing that person's death is an unintended means to achieving a morally good end. However, such an approach is contrary to well settled principles of criminal law. Because of the limitations of judicial law-making, the acceptance of the doctrine in other jurisdictions does not mean it forms part of the Australian common law. At law, to hasten the death "of one who is already dying is treated as killing"[10] Professor Roger Magnusson identifies that it is imperative "that we can distinguish between doctors and killers, and doctors themselves deserve the clearest advice on what separates lawful from unlawful conduct".[11]

The following discussion does not address the euthanasia debate, mercy killing, or assisted suicide; however, it does clarify the operation of the doctrine of double effect and its application to the legal position of a medical practitioner practising palliative care in Australia. The subsidiary normative question raised by the discussion is whether such medical practitioner should be criminally liable for hastening the death of a patient where their intention to relieve intolerable pain and suffering is motivated by compassion.

DOUBLE EFFECT REASONING

The ethical approach of the "doctrine of double effect", "principle of double effect" or "double effect reasoning" (the "doctrine") is seen by many philosophers as "a crucial component of nonconsequentialist

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[5] *Western Australian Report*, n 1, 129.

[6] Parliament of Victoria, *Parliamentary Debates,* Legislative Assembly, 21 September 2017, 2950 (Jill Hennessy, Minister for Health); Parliament of Victoria, *Parliamentary Debates,* Legislative Council, 31 October 2017, 5427 (Gavin Jennings).

[7] See *Airedale NHS Trust v Bland* [1993] AC 789, 865 (Lord Goff).

[8] See C Johnston and J Cameron, "Discussing Voluntary Assisted Dying" (2018) 26(2) JLM 454, 456.

[9] *Victorian Report*, n 1, 111.

[10] D Lanham, "Euthanasia, Painkilling, Murder and Manslaughter" (1994) 1(3) JLM 146, 148.

[11] RS Magnusson, "The Devil's Choice: Re-thinking Law, Ethics and Symptom Relief in Palliative Care" (2006) 34(3) *The Journal of Law, Medicine and Ethics* 559, 561.

moral theories".[12] The application of the doctrine is a manner of reasoning "about whether an act bringing about both a good effect and a bad effect is ethically permissible".[13] The doctrine holds that under certain conditions it is permissible to cause a bad effect if this is incidental to the pursuit of a good end.[14] Central to the application of the doctrine is the crucial distinction between an agent's intention and foresight. The doctrine prohibits intentional killing – which is regarded as an evil effect – but tolerates the causing of death that is merely foreseen and incidental to a morally good effect.[15]

THE THEOLOGICAL DEVELOPMENT OF THE DOCTRINE

The doctrine appears to derive from the reasoning of St Thomas Aquinas (c 1225–1274) and in particular Aquinas' limited use of the reasoning in treatment of questions about self-defence.[16] Aquinas argues that in the context of self-defence, the use of force is permissible in the following way:

> A single act may have two effects, of which one alone is intended, whilst the other is incidental to that intention. But the way a moral act is to be classified depends on what is intended, not on what goes beyond such an intention, since this is merely incidental thereto, … In light of this distinction we can see that an act of self-defence may have two effects: the saving of one's own life and the killing of the attacker. Now such an act of self-defence is not illegitimate just because the agent intends to save his own life, because it is natural for anything to want to preserve itself in being as far as it can. An act that is properly motivated may, nonetheless, become vitiated if it is not proportionate to the end intended. And this is why someone who uses more violence than is necessary to defend himself will be doing something wrong.[17]

In the 16th and 17th centuries the doctrine was further developed by the Catholic Church natural law tradition in response to the exceptionless moral norm prohibiting the intentional killing of the innocent.[18] The development of the doctrine as a tenet of Catholic casuistry was an attempt to reconcile the absolute prohibition against intentionally killing the innocent with conduct that was regarded as legitimate.[19] The doctrine came to be framed in terms such that permitting evil – as opposed to causing evil – was viewed as permissible.[20]

In more recent times the Jesuit theologian Jean Pierre Gury (1801–1866) is credited "for the thorough exposition of this doctrine as a norm applicable to the whole field of moral theology".[21] Gury first formulated the four conditions that must be met in order for a person to legitimately perform an act with a coincident good and evil effect in his influential nineteenth-century manual, *Compendium theologiae moralis*.[22] While the formulation of the four conditions in this kind of reasoning can be expressed in various ways, the following list represents a traditional form of the doctrine:

(1) the act in itself is good or indifferent;
(2) the agent intends the good effect and not the evil effect;
(3) the good effect is not produced by the evil effect; and

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[12] K Lippert-Rassmussen, "Scanlon on the Doctrine of Double Effect" (2010) 36(4) *Social Theory and Practice* 541, 541; see generally FM Kamm, *Intricate Ethics, Rights, Responsibilities, and Permissible Harm* (OUP, 2007) 11.

[13] FJ Connell and C Kaczor, "Double Effect, Principle of" in L Fastiggi (ed), *New Catholic Encyclopedia Supplement 2012-13: Ethics and Philosophy* (Catholic University of America, 2013) Vol 1, 395, 396.

[14] MP Aulisio, "Double Effect, Principle or Doctrine of" in S Garrard Post (ed), *Encyclopedia of Bioethics* (Macmillan, 3rd ed, 2003) 685, 687.

[15] H Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (OUP, 1987) 156.

[16] JT Mangan, "An Historical Analysis of the Principle of Double Effect" (1949) 10(1) *Theological Studies* 41, 42.

[17] T Aquinas, *Summa Theologiæ* (M Lefébure trans, Blackfriars, 1975) Vol 38 (IIaIIæ, Question 64, Article 7) 43.

[18] J Boyle, "Exceptionless Rule Approaches" in H Kuhse and P Singer (eds), *A Companion to Bioethics* (Wiley-Blackwell, 2nd ed, 2009) 107, 113–114.

[19] M Walzer, *Just and Unjust Wars: A Moral Argument with Historical Illustrations* (Basic Books, 5th ed, 2015) 153.

[20] TA Cavanaugh, *Double-effect Reasoning: Doing Good and Avoiding Evil* (OUP, 2006) 23.

[21] Connell and Kaczor, n 13, 397.

[22] Connell and Kaczor, n 13, 397.

(4) there is proportionally grave reason for causing the evil effect.[23]

In its application, the first condition excludes an intrinsically bad act that produces both good and bad effects. An example is Robin Hood stealing from the rich to give to the poor.[24] According to Aristotle an intrinsically bad act, such as murder or theft, cannot be done either well or not well because the act is unconditionally wrong.[25] "The second and third conditions raise important questions about how to distinguish effects that are intended as a means (or an end) from effects that are merely foreseen as side effects."[26] The second condition "stands at the centre of double-effect reasoning … [and] focuses on the intent of the agent".[27] The third condition means, as a matter of causality, that it is impermissible for an agent to use the evil effect to produce the good effect, that is, the evil effect cannot be use as a means to a good end.[28] The fourth condition expresses a balancing exercise that acknowledges that there is no alternative course of action that would cause no, or a relatively lesser, evil effect.[29]

THE RADICAL TRANSFORMATION OF THE DOCTRINE

Admittedly the fourth condition appears consequentialist because it rationalises action based on the balancing of reasons such that a reason to act that outweighs the bad effect can be acted on. In contrast to Catholic moral theology, which purports to deal with how one is to act, "[c]onsequentialism serves as the genus for those ethical theories that propose the right act to be that which produces the greatest net good consequences".[30] To make a consequentialist assessment of reasons "is to think that one's assessment of alternatives within that domain should be governed in a suitable way by the comparative value of the alternatives".[31] In the modern era the doctrine has bridged the divide between these divergent – nonconsequentialist and consequentialist – ethical viewpoints. The "radical transformation of double effect"[32] is framed in terms of proportionalism.[33] Peter Knauer considers that the doctrine permits the evil effect of an act "only if this is not intended in itself but is indirect and justified by a commensurate reason".[34] The idea of an evil effect being justified by a commensurate reason connotes proportionality; unintended effects may be balanced against the intended result and "justified according to the totality of the circumstances".[35] Because "proportionalism shares the common consequentialist commitment that acts cannot be characterized as wrong independently of their consequences",[36] Thomas Cavanaugh considers that "proportionalism transmutes [double effect reasoning] into a consequentialist position".[37]

Henry Sidgwick, a proponent of classic utilitarianism, formulated a rule of proportionality that means that, when framed in such terms, double effect reasoning has broad utilitarian appeal to Just War

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[23] Cavanaugh, n 20, 26.

[24] Cavanaugh, n 20, 26.

[25] Aristotle, *The Nichomachean Ethics* (HG Apostle trans, Peripatetic Press, 1975) 35.

[26] Connell and Kaczor, n 13, 396.

[27] Cavanaugh, n 20, 28.

[28] Cavanaugh, n 20, 29.

[29] Cavanaugh, n 20, 31.

[30] Cavanaugh, n 20, 38–39; see also W Sinnott-Armstrong, "Consequentialism" in EN Zalta (ed), *The Stanford Encyclopedia of Philosophy* (2019) <https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=consequentialism>.

[31] DO Brink, "Some Forms and Limits of Consequentialism" in D Copp (ed), *The Oxford Handbook of Ethical Theory* (University of California-Davis, 2007) 380, 381.

[32] Cavanaugh, n 20, 38–47.

[33] See C Kaczor, "Double Effect Reasoning from Jean Pierre Gury to Peter Knauer" (1998) 59(2) *Theological Studies* 297, 300.

[34] P Knauer, "The Hermeneutic Function of the Principle of Double Effect" [1967] *Natural Law Forum* 127, 132.

[35] D Price, "Euthanasia, Pain Relief and Double Effect" (1997) 17(2) *Legal Studies* 323, 323; see also A Fagothey, *Right and Reason: Ethics in Theory and Practice* (Mosby, 1967) 98.

[36] Cavanaugh, n 20, 39.

[37] Cavanaugh, n 20, 38.

theory.[38] The doctrine has also been relied on to justify causing collateral damage in warfighting by appeal to military necessity;[39] and to justify contemporary arguments in support of waging conflict itself.[40]

THE APPEAL OF THE DOCTRINE TO JUST WAR THEORY

Insofar as the doctrine "bears upon the conduct of war, proportionality compares, for example, the military good one seeks to secure to the harm that one will thereby cause".[41] A simplistic example is that of the strategic bomber, which – subject to necessity and proportionality constraints[42] – seeks to reconcile a legitimate military aim with the prohibition against indiscriminately killing non-combatants.[43]

> In a just war, a pilot drops bombs on an ammunitions factory with the intention of destroying the factory, thereby depriving enemy combatants of ammunition, and ultimately ending the war. The pilot foresees that her raid will inevitably kill a significant number of civilians who live in the city in which the factory is located.[44]

In the above example the pilot foresees the death of some to save the many. By way of contrast is the example of the terror bomber:

> In a just war, a pilot drops bombs on a city with the intention of killing enemy civilians who are close to that target, thereby depriving enemy combatants of the will to fight and ultimately ending the war. The number of civilians that the terror bomber intends to kill through her raid (and, as a matter of fact, kills) is identical to the number the [strategic] bomber (correctly) foresees will be killed by her raid.[45]

In the example of the strategic bomber, the pilot's intention is to cause the death of some to save the many and results in an intuitively different moral evaluation to that of the terror bomber. Kasper Lippert-Rasmussen suggests that "differences in intentions seem to be what explains differences in moral evaluations".[46] However, Shelly Kagan, an opponent to the doctrine, argues '"that in the absence of a deeper account of why intentions should matter in themselves, morally speaking, intuitions … carry little weight."[47] Gerhard Øverland identifies that "it is not clear why the constraint against killing innocent people should be affected by one's not intending their death, or by one's not using them as a means, when their deaths are a foreseeable side effect of one's actions".[48]

The example of the strategic bomber vis-à-vis the terror bomber is simplistic because, at least in Australia's case, there are conventions and laws of armed conflict that constrain military decision-making when there is a real prospect of collateral damage or non-combatant casualties. Outside the

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[38] H Sidgwick, *The Elements of Politics* (Macmillan, 1969) 268; see generally JS Mill, "Utilitarianism" (1863) in A Ryan (ed), *John Stuart Mill and Jeremy Bentham: Utilitarianism and Other Essays* (Penguin Classics, 1987) 272, 278.

[39] See R Wasserstrom, "The Laws of War" in R Wasserstrom (ed), *Today's Moral Problems* (Macmillan, 2nd ed, 1975) 482; see also AE Hartle, *Moral Issues in Military Decision Making* (University Press of Kansas, 2nd ed, 2004) 120–123.

[40] See, eg, GD Brown, *Proportionality for Military Leaders* (BiblioScholar, 2012).

[41] Cavanaugh, n 20, 181.

[42] See S Lazar, "War" in EN Zalta (ed), *The Stanford Encyclopedia of Philosophy* (Spring 2020) <https://plato.stanford.edu/entries/war/>.

[43] See especially Walzer, n 19, 153-154.

[44] Lippert-Rassmussen, n 12, 542.

[45] Lippert-Rassmussen, n 12, 543.

[46] Lippert-Rassmussen, n 12, 543.

[47] Lippert-Rassmussen, n 12, 543, citing S Kagan, *The Limits of Morality* (Oxford Scholarship Online, 1991) 14.

[48] G Øverland, "Moral Obstacles: An Alternative to the Doctrine of Double Effect" (2014) 124 *Ethics* 481, 482.

military context, the doctrine has been applied to end-of-life decisions in the medical context in the case of abortion[49] and palliative care.[50]

THE APPLICATION OF THE DOCTRINE TO END-OF-LIFE DECISIONS IN THE MEDICAL CONTEXT

An early example of the use of the doctrine in the medical context "was to resolve challenges to the Church's prohibition of abortion in cases where continuation of pregnancy would place the mother's life at risk".[51] The paradigm example is a therapeutic hysterectomy where a pregnant woman is diagnosed with aggressive uterine cancer and "unless the uterus is removed, she will die".[52] The doctrine is applied to the example of a therapeutic hysterectomy in the following way:

> On the traditional view, the physician's intended *end* would be *saving the life of the mother* by stopping the spread of cancer through the intended *means* of removing the cancerous uterus. Fetal death, on the traditional view, would properly be described as a foreseen but unintended (bad) side effect of the (good) act of saving the mother's life.[53]

For palliative care, the paradigm example is where a medical practitioner, or a nurse acting on his or her direction,[54] administers a potentially lethal dose of pain medication, such as a large dose of opioids, to a terminally ill patient who is experiencing intolerable pain.[55]

Operating in the background to the application of the doctrine in this context are two assumptions. First, that hastening the death of a terminally ill patient who is experiencing intolerable pain is a harm.[56] In the course of treating the palliated patient, if death is not viewed as a harm, then the doctrine does not apply.[57] Second, that the administration of a large dose of opioids has a foreseeable side-effect of depressing a patient's respiratory system or cough reflex, consequently causing or hastening their death.[58] This is particularly the case for a patient in a severely weakened state.[59] A study published in 1997 (the "1997 study") sought to estimate the proportion of all Australian deaths that involved a medical end-of-life decision. The results included a finding that 30.9% involved alleviation of pain with opioids in doses large enough that there was a probable life-shortening effect.[60]

In the case where a medical practitioner decides to adjust the level of medication by increasing the amount administered to alleviate a patient's pain and suffering knowing there is a risk of causing or hastening death, then, should the patient die as a result, the doctrine construes the medical practitioner's administration of opioids in these circumstances as an intentional act to relieve pain and suffering with

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[49] See A McIntyre, "Doctrine of Double Effect" in EN Zalta (ed), *The Stanford Encyclopedia of Philosophy* (Spring 2019) <https://plato.stanford.edu/archives/spr2019/entries/double-effect/>.

[50] See DP Sulmasy and ED Pellegrino, "The Rule of Double Effect: Clearing Up the Double Talk" (1999) 159(6) *Archives of Internal Medicine* 545; see also TE Quill, R Dresser and DW Brock, "The Rule of Double Effect: A Critique of Its Role in End-of-Life Decision Making" (1997) 337(24) *The New England Journal of Medicine* 1768.

[51] L Tuckey and A Slowther, "The Doctrine of Double Effect and End-of-Life Decisions" (2009) 4 *Clinical Ethics* 12.

[52] Price, n 35, 326.

[53] Aulisio, n 14, 686.

[54] M-J Johnstone, *Bioethics: A Nursing Perspective* (Churchill Livingstone, 4th ed, 2004) 256.

[55] S Bruce, C Hendrix and J Gentry, "Palliative Sedation in End-of-Life Care" (2006) 8(6) *Journal of Hospice and Palliative Nursing* 320, 322.

[56] Compare P Allmark et al, "Is the Doctrine of Double Effect Irrelevant in End-of-Life Decision Making?" (2010) 3 *Nursing Philosophy* 170, 175–176; McIntyre, n 49; J Rachels, "Active and Passive Euthanasia" (1975) 292 *The New England Journal of Medicine* 78, 80.

[57] See McIntyre, n 49, citing Allmark et al, n 56, 170–177.

[58] McIntyre, n 49; Magnusson, n 11, 560–561.

[59] Magnusson, n 11, 561.

[60] H Kuhse et al, "End-of-Life Decisions in Australian Medical Practice" (1997) 166(4) *Medical Journal of Australia* 191, 191.

an unintended albeit foreseen consequences of causing an earlier death.[61] Recalling the traditional form of the doctrine, the example of palliative care involving the administration of a large dose of opioids can be applied in the following way:

(1) the act of administering a large dose of opioids to a patient to relieve intolerable pain and suffering is good in itself, or at least indifferent;
(2) the medical practitioner intends the good effect – the relief of intolerable pain and suffering (as an end) – and not the evil effect – the death of the patient (as a means or an end);
(3) the good effect – the relief of intolerable pain and suffering (as an end) – is not produced by the evil effect – the death of the patient (as a means); and
(4) there is proportionally grave reason for causing the evil effect – to provide relief from intolerable pain and suffering – despite foreseeing that the act of administering a large dose of opioids may hasten or cause the death of the patient.

By application of the doctrine:

> A doctor who intends to hasten the death of a terminally ill patient by injecting a large dose of morphine would act impermissibly because he intends to bring about the patient's death. However, a doctor who intended to relieve the patient's pain with that same dose and merely foresaw the hastening of the patient's death would act permissibly.[62]

The application of the doctrine relies on a distinction between foreseeing and intending death. However, "whether the distinction … is strictly applied by physicians involved in palliative care is debatable".[63] The results of the 1997 study included a finding that that 30% of deaths involved a "medical end-of-life decision … with the explicit intention of ending the patient's life".[64] The results of a 1999 study included a finding that more than 36% of those medical practitioners canvassed reported that, "for the purpose of relieving a patient's suffering, they have given drugs in doses that they perceived to be *greater* than those required to relieve symptoms with the *intention* of hastening death".[65]

A Common Misconception Regarding the Pharmacological Management of Pain

In regard to the responsible administration of drugs to relieve pain, in 1990 the World Health Organization introduced the "analgesic ladder"[66] that has established the internationally recommended approach to the pharmacological management of cancer pain and palliative care by describing "a three-step progression from nonopioid to opioid drugs, depending on an assessment of pain intensity":[67]

> It is a common belief, and the basis of a considerable body of legal and legislative opinion, that morphine dose is the main determinant of whether the drug causes or hastens death. In fact, there is no such determinative or threshold dose, and this approach is flawed. What matters is the present dose in relation to the previous dose. Gradual dose escalation by a factor in the region of 50 to 100 per cent of the previous dose is usual practice, although substantially higher increases can usually be well tolerated by patients

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[61] Quill, Dresser and Brock, n 50, 1768–1769; see also G Williams, "The Principle of Double Effect and Terminal Sedation" (2001) 9(1) *Medical Law Review* 41, 41–42; see also MFA Otlowski, *Voluntary Euthanasia and the Common Law* (Clarendon Press, 1997) 174.

[62] McIntyre, n 49; see also Bruce, Hendrix and Gentry, n 55, 322.

[63] Magnusson, n 11, 561.

[64] Kuhse et al, n 60, 191; see also Magnusson, n 11, 561.

[65] CD Douglas et al, "The Intention to Hasten Death: A Survey of Attitudes and Practices of Surgeons in Australia" (2001) 175(10) *Medical Journal of Australia* 511, 511.

[66] See World Health Organization, *Cancer Pain Relief* (1986); World Health Organization, *Cancer Pain Relief and Palliative Care* (1990); World Health Organization, *Cancer Pain Relief, With a Guide to Opioid Availability* (1996).

[67] M Ashby and K Jackson, "When the WHO Ladder Appears to Be Failing: Approaches to Refractory or Unstable Cancer Pain" in N Sykes, MT Fallon and RB Patt (eds), *Clinical Pain Management: Cancer Pain* (OUP, 2003) Vol 3, 143.

> who are not new to the drug (that is, they are no longer "opioid-naive"). It is therefore the size of the initial dose and the rate of subsequent increases which are important.[68]

Premised on the claim that the administration of opioids in appropriate doses does not hasten the death of the palliated patient by causing respiratory depression,[69] the argument is that there is no need for resort to the doctrine of double effect. It is argued that the doctrine has no application in the context of palliative care because hastening a patient's death is not a foreseeable side-effect when opioids are administered appropriately and carefully.[70] In evidence given to the Western Australian Inquiry, an Australian study looked at doses of sedating medications and opioid medications in people in a palliative care unit who died and concluded that "the use of these medications, in good quality palliative care, does not hasten death".[71] This supports the argument that health practitioners do not need to rely of the doctrine as a justification for the administration of opioids. However, the argument fails in the situation where pain cannot be controlled.

THE HORNS OF A DILEMMA

While most palliated patients obtain acceptable levels of pain and symptom control through the administration of medication, there are "situations in which the interventions that it describes 'fail' to achieve acceptable pain control".[72] It is recognised that even with access to the best quality palliative care "the idea that modern palliative care can relieve *all* suffering associated with death and dying is a flawed approach":[73]

> Some far advanced and terminally ill cancer patients experience symptoms that cannot be controlled even by the best supportive and palliative therapies.[74]

The Canadian Senate Report of the Special Senate Committee on Euthanasia and Assisted Suicide identified that there are limits to the use of opioid analgesics: "[t]here are two or three pain syndromes that are particularly difficult for us to treat, nerve pain, bone pain and pain that is largely comprised of suffering in the psychological sphere."[75] Similarly, in the context of receiving extensive evidence about "bad deaths", the Western Australian Inquiry identified that "[i]t is clear that there are limits to modern medicine".[76] In the circumstance where the palliated patient is unable to obtain acceptable levels of pain and symptom control through the administration of medication a medical practitioner is in a dilemma in that he or she is faced with a choice between relieving pain through administering increasingly large doses of medication with the probable consequence of hastening death, or potentially "giving inadequate symptom relief in order not to shorten life".[77]

HEAVY SEDATION

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[68] M Ashby, "Hard Cases, Causation and Care of the Dying" (1995) 3 JLM 152, 157.

[69] See B White, L Wilmott and M Ashby, "Palliative Care, Double Effect and the Law in Australia" (2011) 41(6) *Internal Medicine Journal* 485, 486–487; see also M Maltoni et al, "Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study" (2009) 20(7) *Annals of Oncology* 1163, 1164, 1167; compare H McCabe, "End-of-Life Decision-making, the Principle of Double Effect, and the Devil's Choice: A Response to Roger Magnusson" (2008) 16 JLM 74, 78.

[70] SA Fohr, "The Double Effect of Pain Medication: Separating Myth from Reality" (1998) 1(4) *Journal of Palliative Medicine* 315; *contra* Allmark et al, n 56, 172–173.

[71] Dr Campbell, President, Palliative Care WA, JSCEOLC Transcript, 14 December 2017, Session 4, 10, cited in Legislative Assembly Joint Select Committee on End of Life Choices, Parliament of Western Australia, *Minority Report: The Safe Approach to End of Life Choices: Licence to Care Not Licence to Kill*, 23.

[72] Ashby and Jackson, n 67, 143.

[73] Ashby, n 68, 155; see also *Western Australian Report*, n 1, 107, 203.

[74] Maltoni et al, n 69, 1163.

[75] Special Senate Committee on Euthanasia and Assisted Suicide, Senate of Canada, *Of Life and Death* (1995) 19.

[76] *Western Australian Report*, n 1, 203.

[77] Magnusson, n 11, 566.

The effect of the difficult pain management situations most resistant to standard treatments means that "[h]eavy sedation may be used to induce a state of impaired consciousness"[78] in order to provide relief from pain and symptom control.[79] Although such treatment is within accepted palliative care practice,[80] it is "impossible to state that such treatment does not have the potential to shorten life".[81] In these situations the doctrine has a role to play because ostensibly if death results, it is not intended but it is foreseen.

THE EXTENSION OF PALLIATIVE CARE TO PALLIATIVE SEDATION

In response to the limitations of palliative care in those situations where pain is difficult to treat, in the United States palliative care has been extended in practice to palliative sedation (sedation to unconsciousness). In 1994 Nathan Cherny and Russell Portenoy proposed the definition of "refractory symptom" to mean: "symptom for which all possible treatment has failed, or it is estimated that no methods are available for palliation within the time frame and the risk-benefit ratio that the patient can tolerate."[82] Palliative sedation therapy means "the use of sedative medications to relieve intolerable suffering from refractory symptoms by a reduction in patient consciousness".[83] Palliative sedation therapy is also termed "terminal sedation"[84] or "pharmacological oblivion"[85] (among other synonymous expressions[86]).

Both palliative care and palliative sedation have the common aim to provide relief from intolerable pain and suffering, and both regimes can involve the administration of high doses of medication. However, in the case of palliative sedation, the administration of sedatives causes the patient to become unconscious or comatose by design – the intention is to induce sedation until death from the underlying cause.[87]

A distinction between palliative care and palliative sedation is that death is foreseeable with the former and inevitable with the latter (whether by the sedation process itself, the ultimate consequence of withholding or withdrawing artificial nutrition and hydration or by the patient's underlying condition). Proponents of palliative sedation argue that death is not intended;[88] and this therefore provides ethical justification for the practice. Although palliative sedation is recognised as a legitimate form of treatment in the United States,[89] this type of therapy is ethically controversial and has been described as a "slow and disguised form of euthanasia because death often comes fairly rapidly after sedation".[90]

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[78] Ashby and Jackson, n 67, 156.

[79] Magnusson, n 11, 561.

[80] See Williams, n 61, 42.

[81] Ashby and Jackson, n 67, 156.

[82] NI Cherny and RK Portenoy, "Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment" (1994) 10(2) *Journal of Palliative Care* 31, cited in Maltoni et al, n 69, 1163.

[83] Maltoni et al, n 69, 1163; see also Bruce, Hendrix and Gentry, n 55, 321.

[84] EH Loewy, "Terminal Sedation, Self-starvation, and Orchestrating the End of Life" (2001) 161(3) *Archives of Internal Medicine* 329, 329.

[85] R Syme, "Pharmacological Oblivion Contributes to and Hastens Patient's Deaths" (1999) 18(2) *Monash Bioethics Review* 40, 40; see also Magnusson, n 11, 561.

[86] Bruce, Hendrix and Gentry, n 55, 321.

[87] MP Hahn, "Review of Palliative Sedation and Its Distinction from Euthanasia and Lethal Injection" (2012) 26 *Journal of Pain & Palliative Care Pharmacotherapy* 30, 30; see also Williams, n 61, 41–42.

[88] Williams, n 61, 41–42.

[89] K O'Reilly, "AMA Meeting: AMA OKs Palliative Sedation for Terminally Ill", *American Medical News*, 7 July 2008 <https://amednews.com/article/20080707/profession/307079953/7/>.

[90] Maltoni et al, n 69, 1167 citing AJ Billings and SD Block, "Slow Euthanasia (a Tacit Acceptance by the Medical Community under Particular Circumstances May Also Reflect Professional Reasoning That May Be Ethically Muddled)" (1996) 12(4) *Journal of Palliative Care* 21; see also Bruce, Hendrix and Gentry, n 55, 322; see also G Schofield et al, "Palliative Opioid Use, Palliative

> Terminal sedation is done with the full knowledge that no further active treatment will be done and that patients, as rapidly as possible, will now die as a result of their underlying disease process. The claim is made that such a way of proceeding is aimed at providing maximal relief of pain and suffering – the death of the patient is "not intended." But that is, to say the least, disingenuous. Patients are intentionally kept asleep, their vital functions are deliberately not artificially supported, and they are allowed to die in comfort.[91]

However, recalling that the application of the doctrine relies on a distinction between foreseeing and intending death, from a legal perspective, if a patient's death is caused or hastened by the palliative care provided, any distinction between foreseeing and intending death is irrelevant.

THE INTERSECTION OF ETHICAL JUSTIFICATION AND CRIMINAL LIABILITY

In the context of proper medical care "[t]he growing tension between the dual roles of sustaining life and relieving suffering has resulted in an expanding debate on what constitutes right, correct or proper medical care for the terminally ill or severely ill".[92] "The law also has a policy interest in avoiding painful deaths".[93] Herein lies the crux of the problem. Although the doctrine is relied upon in the context of palliative care to provide moral justification when a foreseeable side-effect is that treatment will probably cause death, in Australia, the doctrine does not provide legal justification. Although the subject matter of palliative care is inherently medical, "the criminal law concepts of intention and causation are the governing factors in establishing blameworthiness and liability".[94] The orthodox proposition of criminal causation is that "shortening life involves causing death".[95] In conjunction with this proposition, if medication is administered – or caused to be administered – to a terminally ill patient by a medical practitioner and the medical practitioner foresees that the administration of the medication will probably cause or hasten death – and it does – then following an orthodox application[96] of criminal law principles, the medical practitioner may be liable for murder.[97]

CRIMINAL LIABILITY FOR MURDER

Criminal liability for murder is established by concurrence of the legal concepts of causation and intention.

The Physical Element – Conduct Causing Death

If a medical practitioner administers to his or her patient medication that shortens life, as a matter of common sense there will likely be no obstacle to proving beyond reasonable doubt that the medical

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Sedation and Euthanasia: Reaffirming the Distinction" (2020) 46(1) *Journal of Medical Ethics* 48, 49; see also Williams, n 61, 41; see also Loewy, n 84, 331; see also Rachels, n 56, 80.

[91] Loewy, n 84, 331.

[92] CA Stevens and R Hassan, "Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia" (1994) 20 *Journal of Medical Ethics* 41, 44–45.

[93] B White and L Willmott, "Double Effect and Palliative Care" in B White, F McDonald and L Wilmott (eds), *Health Law in Australia* (Lawbook, 2014) 593.

[94] G Williams, *Intention and Causation in Medical Non-killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge-Cavendish, 2007) 7.

[95] A Ashworth, *Principles of Criminal Law* (OUP, 5th ed, 2006) 126.

[96] See A Norrie, *Crime, Reason and History: A Critical Introduction to Criminal Law* (CUP, 2nd ed, 2001) 47–49.

[97] Otlowski, n 61, 170, 182.

practitioner's voluntary conduct[98] was objectively[99] an operating and substantial cause[100] of death.[101] The relevant conduct need not be a direct cause of death, for a person may cause the death of another through the agency of others,[102] such as in the case of a medical practitioner instructing a nurse to administer a dose of medication that proves fatal. The relevant conduct need not be the sole cause of death,[103] such as in the case where a terminally ill patient is suffering from an underlying condition. The relevant conduct need not be the immediate cause of death – it may precipitate a chain of events that ultimately results in the death of another person,[104] such as in the case of administering a large dose of opioids that has a side-effect of depressing a patient's respiratory system or cough reflex, consequently causing or hastening their death. The physical element may also comprise multiple aspects – "there may be several causes and more than one person may be criminally responsible for the death".[105] Therefore, by reference to the doctrine, the lawfulness of a medical practitioner's conduct must turn "on factors other than causation".[106]

The Fault Element – Intentionally Causing Death

If a medical practitioner administers to his or her patient medication that shortens life, in addition to establishing causation, criminal liability for murder depends on an assessment of intention. In Australia, jurisdictions vary in the fault element required for murder: "[w]hile all jurisdictions include an intention to kill within the fault elements, seven include an intention to cause some form of serious bodily harm, five include recklessness as to causing death and … [and] two include recklessness as to causing grievous bodily harm".[107] Because the doctrine has no role to play where a person acts with a purpose to kill,[108] (ie, where death is intended as an end) the proceeding analysis will confine discussion of intention for murder to that of recklessness.

RECKLESSNESS

The term "recklessness" "describes the state of mind of a person who, whilst performing an act, is aware of a risk that a particular consequence is *likely* to result".[109] The word "likely" is used in "its ordinary meaning, namely, to convey the notion of a substantial – a 'real and not remote' – chance".[110]

COMMON LAW JURISDICTIONS

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[98] *Woolmington v DPP* [1935] AC 462; *Ryan v The Queen* (1967) 121 CLR 205; *R v Falconer* (1990) 171 CLR 30, 37 (Mason CJ, Brennan and McHugh JJ); *R v Pagett* (1983) 76 Cr App R 279, 289.

[99] *Royall v The Queen* (1991) 172 CLR 378, 393 (Mason CJ).

[100] *R v Smith* [1959] 2 QB 35; *Royall v The Queen* (1991) 172 CLR 378, 398 (Brennan J), 411 (Deane and Dawson JJ), 423 (Toohey and Gaudron JJ).

[101] See generally *R v Pagett* (1983) 76 Cr App R 279, 290–291; see also E Colvin, "Causation in Criminal Law" (1989) 1(2) *Bond Law Review* 253, 259; see also Ashworth, n 95, 126.

[102] LexisNexis, *Halsbury's Laws of Australia* online (at 11 March 2020) 130 Criminal Law, "2 Elements of Crime" [130-65], citing *R v Michael* (1840) 169 ER 48; *Muhandi v The Queen* [1957] Crim LR 814.

[103] *R v Pagett* (1983) 76 Cr App R 279.

[104] *R v Hallett* [1969] SASR 141, 149.

[105] J Clough and C Mulhern, *Criminal Law* (LexisNexis, 2nd ed, 2004) 10–11. Need for Updating with 3rd Edition.

[106] Lanham, n 10, 150.

[107] S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson Lawbook, 2nd ed, 2005) 468.

[108] See *R v Cox* (1992) 12 BMLR 38, 41; see also A Grubb, "Attempted Murder of Terminally Ill Patient: R v Cox" (1993) 1(2) *Medical Law Review* 232, 232–234; see also D Lanham et al, *Criminal Laws in Australia* (Federation Press, 2006) 183.

[109] B McSherry and B Naylor, *Australian Criminal Laws: Critical Perspectives* (OUP, 2004) 179.

[110] *Boughey v The Queen* (1986) 161 CLR 10, 21 (Gibbs CJ).

Based on their criminal law, the common law jurisdictions of Australia are Victoria, New South Wales and South Australia.[111] Each of these jurisdictions has legislation which builds upon the common law; however, such legislation is interpreted in the light of settled common law principles and all common law offences continue to exist unless abrogated by statute.[112] Murder is a common law offence. In the common law jurisdictions, the meaning of intention for murder includes recklessness – or reckless indifference[113] – as to causing the death of another, with the broadest approach being taken by Victoria and South Australia in including recklessness as to the infliction of grievous bodily harm.[114] The authority for this is *R v Crabbe*.[115]

The case of *R v Crabbe* concerns a truck driver who, after consuming a substantial amount of alcohol and having been physically ejected from a crowded bar in a Motel, drove his prime mover – with trailer attached – through the wall of the Motel and into the bar. As a result, five people died, and more were injured. In *R v Crabbe* the court held *per curiam*:

> The conduct of a person who does an act, knowing that death or grievous bodily harm is a probable consequence, can naturally be regarded for the purposes of the criminal law as just as blameworthy as the conduct of one who does an act intended to kill or to do grievous bodily harm.[116]

Although the doctrine holds that consequences can be unintended, albeit foreseen, this cannot be reconciled with the fault element for murder. At common law, unintended consequences may be caught under the aegis of recklessness.

THE CODE JURISDICTIONS

The Criminal Code jurisdictions of Australia include Queensland, Tasmania, Western Australia and the Northern Territory. These jurisdictions have enacted codes that seek to provide a comprehensive statement of the criminal law. The codes are interpreted on the understanding that they are intended to replace the common law.[117] By reference to the various codes, the fault element for murder (manslaughter in the Northern Territory[118]) constituted by recklessness is described in the following table.

Jurisdiction	The Fault Element Includes:	Legislative Provision
Queensland	" with reckless indifference to human life;"	*Criminal Code Act 1899* (Qld) s 302(1)(aa)
Tasmania	"an intention to cause to any person, whether the person killed or not, bodily harm which the offender knew to be likely to cause death in the circumstances, although he had no wish to cause death;"	*Criminal Code Act 1924* (Tas) Sch 1 s 157(1)(b)

[111] LexisNexis, *Halsbury's Laws of Australia*, online (at 11 March 2020) 130 Criminal Law, "I Principles of Criminal Liability" [130-5].

[112] LexisNexis, *Halsbury's Laws of Australia*, n 111, citing *R v Crimmins* [1959] VR 270; *Radak v Daire* (1982) 30 SASR 60; *Sibuse Pty Ltd v Shaw* (1988) 13 NSWLR 98.

[113] *Crimes Act 1900* (NSW) s 18(1)(a).

[114] Bronitt and McSherry, n 107, 468.

[115] *R v Crabbe* (1985) 156 CLR 464.

[116] *R v Crabbe* (1985) 156 CLR 464, 469 [8].

[117] LexisNexis, *Halsbury's Laws of Australia*, n 111.

[118] The fault element is included in the definition of murder: *Criminal Code Act 1983* (NT) s 279. The fault element includes an intention to cause death of or serious harm: *Criminal Code Act 1983* s 156. Recklessness is not sufficient as a fault element for murder; however, the Code separately provides that where a person is reckless as to causing the death of another person, a person is guilty of manslaughter: *Criminal Code Act 1983* s 160.

Western Australia	"intends to cause a bodily injury of such a nature as to endanger, or be likely to endanger, the life of the person killed"	*Criminal Code Act Compilation Act 1913* (WA) App B s 279(1)(b)
Northern Territory	"is reckless … as to causing the death of that … person"	*Criminal Code Act 1983* (NT) Sch 1 s 160(c)

THE AUSTRALIAN CAPITAL TERRITORY

The Australian Capital Territory has partially applied a Code.[119] In the Australian Capital Territory, the fault element is included in the definition of murder[120] and includes to cause the death of another person "with reckless indifference to the probability of causing the death of any person".[121] The meaning of recklessness is codified to include that a person reckless if "the person is aware of a substantial risk that the result will happen; and having regard to the circumstances known to the person, it is unjustifiable to take the risk".[122]

THE IRRELEVANCE OF MOTIVE

In terms of the fault element for murder, "[a] motive for murder need not be proved".[123] Motive is not the same as intention[124] and, in criminal law, motive is generally not considered relevant to the question of fault.[125] There are reasons for this. A court may be faced with insuperable challenges if such an enquiry were required.[126] Also, consideration of motive would accommodate "law-breaking on account of acute personal need".[127] To accommodate motive impliedly undermines the rule of law by allowing room for individual notions of right and wrong, or the application of "higher values" that may be inconsistent with those implicit in the law.[128] An approach that accommodated consideration of motive – good or bad – would minimise "the role played by legal specificity in the definition of *mens rea*",[129] and in a limited sense extend the role of the jury beyond one of fact finding to that of a moral evaluator of conduct.[130]

The orthodox tradition[131] of the criminal law is an approach that involves a formal enquiry into an accused's purpose that describes a "'factual' view of responsibility based on an accused's mental control over actions".[132] This approach disentitles a jury from differentiating the moral quality[133] of acts following from motives or "values identified in a particular action and the mental state accompanying

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[119] *Criminal Code 2002* (ACT) s 5.

[120] *Crimes Act 1900* (ACT) s 12.

[121] *Crimes Act 1900* (ACT) s 12(1)(b).

[122] *Criminal Code 2002* (ACT) s 20.

[123] Bronitt and McSherry, n 107, 468.

[124] *R v Clarke* (1927) 40 CLR 227, 232 (Isaacs ACJ).

[125] See *Hyam v DPP* [1975] AC 55, 73 (Lord Hailsham); see also *R v Clarke* (1927) 40 CLR 227, 232 (Isaacs ACJ); *La Fontaine v The Queen* (1976) 136 CLR 62, 98 (Jacobs J); *R v Rogers* (1996) 86 A Crim R 542, 546 (Gleexon CJ); Bronitt and McSherry, n 107, 180, 655.

[126] *La Fontaine v The Queen* (1976) 136 CLR 62, 98 (Jacobs J).

[127] Norrie, n 96, 37.

[128] See also *R v Rogers* (1996) 86 A Crim R 542, 546 (Gleexon CJ).

[129] J Horder, "Intention in Criminal Law – A Rejoinder" (1995) 58 *Modern Law Review* 678, 685.

[130] Horder, n 129, 687.

[131] See generally A Norrie, "From Criminal Law to Legal Theory: The Mysterious Case of the Reasonable Glue Sniffer" (2002) 65(4) *Modern Law Review* 538, 539, 542; see also Norrie, n 96, 47–49.

[132] Norrie, n 96, 50.

[133] J Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legislation* (CUP, 2002) 18.

it".[134] The effect of the orthodox approach is to treat as equivalent the mercy killer and the contract killer,[135] as both have acted with intention.[136] Motive may serve an evidentiary role in attributing intention through the adducing of circumstantial evidence;[137] however, generally consideration of motive is restricted to the sentencing stage following a finding of guilt.

THE RECOGNITION OF THE DOCTRINE AT COMMON LAW BY SUPERIOR COURTS IN OVERSEAS JURISDICTIONS

Commentators[138] consider that the doctrine was first given legal recognition at common law in the United Kingdom in 1957 by [then] Lord Justice Devlin in the case of *R v Bodkin-Adams*,[139] and stands as "authority for the proposition that a doctor whose primary intention is to relieve pain, even if life is incidentally shortened, has an exceptional defence to murder".[140]

R v Bodkin-Adams

Dr Bodkin-Adams was charged with murder after increasing the dosage of opiates administered to his elderly stroke patient. Lord Devlin recounts that in June 1948 Mrs Morrell, then approximately 79 years of age, suffered "a stroke which left her paralysed on the left side".[141] In July, Mrs Morrell became one of Dr Adams' patients and progressively deteriorated, becoming bedridden in early 1949. During the ten-and-a-half month period preceding her death on 13 November 1950, Dr Adams prescribed for her large quantities of heroin and morphia. In her last days, Dr Adams prescribed for her so large a quantity of heroin and morphia that colleagues considered there to be "no medical justification for these doses, which she could not survive";[142] whereas Dr Adams claimed that the drugs had been administered to relieve his patient's pain. The case "thereby raised the question of whether doctors were entitled to adopt a course of treatment that would have the effect of shortening the patient's life".[143] This question was considered by the court over a period of 17 days and in summing up to the jury Lord Devlin J said:

> Murder is an act, or a series of acts, which were intended to kill and did, in fact, kill. It does not matter for this purpose if death was inevitable. If life was cut short by weeks or months it is just as much murder as if it were cut short by years.
>
> There has been a good deal of discussion about the circumstances in which a doctor might be justified in giving drugs which would shorten life in cases of severe pain. It is my duty to tell you that the law knows of no special defence of this character. But that does not mean that a doctor aiding the sick or the dying has to calculate in minutes or hours, or perhaps in days or weeks, the effect on a patient's life of the medicines which 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

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[134] Norrie, n 96, 50.

[135] Norrie, n 131, 538.

[136] See, eg, *R (on the Application of Pretty) v DPP* [2002] 1 AC 800, 826 (Lord Bingham), 831 (Lord Steyn); [2001] UKHL 61.

[137] See *Plomp v The Queen* (1963) 110 CLR 234 (Dixon CJ, Kitto, Taylor, Menzies and Windeyer JJ); see also *R v Clarke* (1927) 40 CLR 227, 232 (Isaacs ACJ).

[138] See, eg, Keown, n 133, 22; see also A McGee, "Double Effect in the Criminal Code 1899 (Qld): A Critical Appraisal" (2004) 4(1) *Queensland University of Technology Law and Justice Journal* 46, 47.

[139] *R v Bodkin-Adams* [1957] Crim LR 365.

[140] Williams, n 94, 36–37; see also M Stauch and K Wheat with J Tingle, *Text, Cases and Materials on Medical Law* (Routledge, 3rd ed, 2006) 645–646.

[141] Lord P Devlin, *Easing the Passing: The Trial of Dr John Bodkin* (The Bodley Head, 1985) 2.

[142] Devlin, n 141, 5.

[143] Otlowski, n 61, 172.

> to do all that is proper and necessary to relieve pain or suffering, even if the measures he took might incidentally shorten life.[144]

The jury, having considered these and other points, found Dr Adams not guilty. The case of *R v Bodkin-Adams*[145] is of lasting significance because of the legal issue under consideration at the time – whether doctors were entitled to adopt a course of treatment that would have the effect of shortening a patient's life – and because it is one of the first common law authorities directly dealing with the issue.[146] The principles stated by Lord Devlin came to be accepted by legal writers[147] and English Judges;[148] incrementally developed[149] and nearly extended in the (discontinued) case of Annie Lindsell in 1997.[150] The principles have also come to be recognised as part of the common law in other overseas jurisdictions;[151] however, not in Australia. This is because of the limitations of judicial law-making.

THE LIMITATIONS OF JUDICIAL LAW-MAKING

Unlike the legislature, the judiciary is limited in its power to translate policy into common law. Judicial officers are limited by the necessity to present their conclusions in reasoned judgments, constrained by precedent and argument by analogy. The Hon Sir Anthony Mason writing extra-curially said:

> The permissible limits of judicial law-making are closely associated with the doctrine of precedent of which one element is *stare decisis. Stare decisis* obliges a court to give effect to its previous decisions.[152]

The doctrine of precedent means that a decision of a superior court on a matter of law for a case on similar facts is binding authority on all courts below it in the judicial hierarchy. In Australia, a decision of the High Court is binding on all other courts. A decision of a superior overseas court; however, is *not* binding (albeit such a decision – particularly from the United Kingdom – is persuasive).

In accordance with *R v Crabbe* the degree of recklessness to satisfy the fault element for murder is that of probability. In terms of the doctrine of precedent, the element of *stare decisis* is "subject to the qualification … that a court is not bound to follow a decision which the court holds to be wrong". However, it is unlikely that any court in Australia will be convinced that the decision of *R v Crabbe* is "plainly wrong".[153] The element is of *stare decisis* is also "subject to the qualification that the High

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[144] *R v Bodkin-Adams* [1957] Crim LR 365, 375.

[145] *R v Bodkin-Adams* [1957] Crim LR 365.

[146] Otlowski, n 61, 172.

[147] L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) 303; see also Williams, n 94, 33–37; Select Committee on Medical Ethics, House of Lords, *Report of the Select Committee on Medical Ethics* (1994) 49–50; A Arlidge, "The Trial of David Moor" [2000] *Criminal Law Review* 31.

[148] *R v Cox* [1992] 12 BMLR 38, 41 (Ognall J).

[149] *Airedale NHS Trust v Bland* [1993] AC 789, 867 (Lord Goff); see also JM Finnis, "Bland: Crossing the Rubicon" (1993) 109 *Law Quarterly Review* 329, 226.

[150] See J Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation* (CUP, 2nd ed, 2018) 26-28 referring to *The Matter of Ann Lindsell v Simon Holmes* (discontinued); , n 133, 23; see also "Health: Euthanasia Campaign Steps up Pressure", *BBC News*, 31 October 1998, <http://news.bbc.co.uk/2/hi/health/204559.stm>; see also M Stauch, K Wheat and J Tingle, *Sourcebook on Medical Law* (Cavendish Publishing, 2nd ed, 2002) 682.

[151] *Rodriguez v British Columbia (A-G)* [1993] 2 SCR 519, 590 (Sopinka J); see also Canadian Law Reform Commission, *Euthanasia, Aiding Suicide and Cessation of Treatment*, Working Paper No 28 (1982) 70; *Vacco v Quill*, 521 US 793, 808 (1997) (Rehnquist CJ, Connor, Scalia, Kennedy and Thomas JJ), citing New York State Task Force on Life and the Law, "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context" (1994) 163, citing American Medical Association, Council on Ethical and Judicial Affairs, *Current Opinions* (1989) s 2.20, 13 <https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/chap8.htm>; *Auckland Area Health Board v A-G (NZ)* [1993] 1 NZLR 235, 252 [25] (Thomas J).

[152] Sir A Mason, "Legislative and Judicial Law-making: Can We Locate an Identifiable Boundary?" (2003) 24(1) *Adelaide Law Review* 15, 23.

[153] See *Farah Constructions Pty Ltd v Say-Dee Pty Ltd* (2007) 230 CLR 89, 151–152 [135]; [2007] HCA 22.

Court of Australia is not bound by its previous decisions".[154] However, to date there is no case that squarely deals with the question of whether the act of a medical practitioner who administers a lethal dose of medication with the intention to relieve pain while foreseeing the medication will probably cause or hasten the death of his or her patient is justifiable. Therefore, until the question is squarely before – and answered by – the High Court, the doctrine does not provide a legal defence for a medical practitioner who has recklessly caused the death of a patient.

STATUTORY PROTECTION IN AUSTRALIA

The legislature is not limited in its power to translate policy into law. Three State legislatures have enacted recognition of a modified version of the doctrine in order to provide protection for a medical practitioner – or a person under their supervision or at their direction – providing appropriate palliative care.

South Australia

In South Australia the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) was enacted in response to the legislative recommendations of the Select Committee into the Law and Practice Relating to Death and Dying. A submission to that committee identified that in the context of palliative care the onset of death of a patient may be accelerated by medical practitioners operating under the aegis of the principle of double effect; however, "doctors may feel a risk of prosecution, despite exercising the highest standards of clinical care in what they believe to be the best interests of the patient".[155] Section 17(1) of the Act now operates to protect medical practitioners where "an incidental effect of the treatment is to hasten the death of the patient".[156]

Queensland

In Queensland, the *Criminal Code Act 1899* (Qld) contains provisions that outline the circumstances in which a person is deemed to have killed another and includes hastening their death.[157] The effect of these provisions is that, in the absence of a statutory defence, where the effect of providing appropriate palliative care is to hasten the person's death, a medial practitioner is liable for murder. As a consequence of the potential criminal liability faced by medical practitioners, the *Criminal Code (Palliative Care) Amendment Act 2003* (Qld) was enacted. The object of this legislation is to:

> [C]larify the obligations of doctors treating terminally-ill patients and to ensure that doctors, including those who follow their orders, who administer palliative care to such patients for the purpose of relieving pain and suffering, are not held under threat of prosecution because an incidental effect of the treatment is to shorten the life of the patient.[158]

In Queensland, s 282A of the *Criminal Code Act 1899* (Qld) now operates where a medical practitioner, or a person acting on their written order, provides appropriate palliative care in good faith and "an incidental effect of providing the palliative care is to hasten the other person's death".[159]

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[154] Mason, n 152, 23, citing *Damjanovic & Sons Pty Ltd v Commonwealth* (1968) 117 CLR 390, 395–396; *Queensland v Commonwealth* (1977) 139 CLR 585, 593–594, 602; *Baker v Campbell* (1983) 153 CLR 52, 102.

[155] Select Committee of House of Assembly on the Law and Practice Relating to Death and Dying, Parliament of South Australia, House of Assembly, *Second Interim Report of the Select Committee on the Law and Practice Relating to Death and Dying* (1992) 8; see also Evidence to the Select Committee of House of Assembly on the Law and Practice Relating to Death and Dying, Parliament of South Australia, House of Assembly, Adelaide, 1997, 7 (M Ashby, L Maddocks, C Reynolds, D Order, B Stoffel, J Beilby and M Wakefield).

[156] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(1); see also South Australia, *Parliamentary Debates,* Legislative Council, 5 August 1993, 60 (The Hon Anne Levy, for the Hon Barbara Wiese).

[157] *Criminal Code Act 1899* (Qld) s 296.

[158] Explanatory Memorandum, *Criminal Code (Palliative Care) Amendment Bill 2003* (Qld) 1.

[159] *Criminal Code Act 1899* (Qld) s 282A(2).

Western Australia

In Western Australia, the *Criminal Code Act Compilation Act 1913* (WA) contains provisions that outline the circumstances in which a person is deemed to have killed another and includes acceleration of death.[160] As a consequence of the potential criminal liability faced by medical practitioners practicing palliative care, the *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) was enacted. The *Criminal Code Act Compilation Act 1913* (WA) now provides that "[a] person is not liable for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) … 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".[161]

Therefore, in South Australia, Queensland and Western Australia, the proper provision of palliative care may be subsumed within the ambit of lawful homicide.[162] However, outside of these jurisdictions, the act and intention of a medical practitioner – or a person under their supervision or at their direction – who provides appropriate palliative care that hastens a patient's death must be reconciled with the common law.[163]

SHOULD A MEDICAL PRACTITIONER BE CRIMINALLY LIABLE FOR CAUSING OR HASTENING THE DEATH OF A PATIENT WHERE THEIR INTENTION IS TO RELIEVE INTOLERABLE PAIN AND SUFFERING?

The Victorian Inquiry recognises that "[t]he nature of medical decision-making at the end of life gives rise to legal risk".[164] In the situation where a medical practitioner foresees that death is a probable consequence of providing palliative care, the observation of Loan Skene is apposite:

> It is true that doctors are rarely prosecuted, but the fact is that this is an intentional act, and it makes no difference that the patient has requested it or even that the patient is in the process of dying. It is still a criminal offence.[165]

In the case where a medical practitioner adopts a course of treatment with the purpose of relieving the pain and suffering of his or her patient foreseeing that life will probably be shortened, if death results there is an evident incongruity between the legal result obtained by applying orthodox principles of criminal law and our sense of moral culpability.[166] In this situation the label is murderer; however, the degree of moral blameworthiness of a medical practitioner is less than that of the contract killer.

It is acknowledged that a medical practitioner may be motivated to act by reason of compassion and "these cases don't sit comfortably in a court setting".[167] In the present legal landscape, although the law is fairly clear, it is difficult "to fit within its rubric deserving cases where the law seems to produce an unjust result".[168] Where a medical practitioner is motivated to act by compassion, "leniency is demonstrated in the exercise of prosecutorial discretion in accepting guilty pleas to lesser charges and judicial discretion in the imposition of non-custodial sentences".[169]

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[160] *Criminal Code Act Compilation Act 1913* (WA) App B ss 270, 273.

[161] *Criminal Code Act Compilation Act 1913* (WA) App B s 259.

[162] LexisNexis, *Halsbury's Laws of Australia* online (at 16 March 2020) 130 Criminal Law, "(A) Homicide" [130-3000].

[163] In Tasmania, although the *Care and Consent to Medical Treatment Bill 2016* (Tas) contemplates statutory recognition of a modified version of the doctrine in near identical terms to the South Australian legislation; presently there is no statutory protection for medical practitioners.

[164] Evidence to Victorian Inquiry, Melbourne, 23 July 2015, cited in *Victorian Report*, n 1, 184 (Loan Skene).

[165] Otlowski, n 61, 10, cited in *Victorian Report*, n 1, 173.

[166] See especially *La Fontaine v The Queen* (1976) 136 CLR 62, 98 (Jacobs J).

[167] Justice John Coldrey in K Quinn, "Andrew Denton Is Back with Better Off Dead, a Podcast about the Right to Die", *The Age*, 8 February 2016, cited in *Victorian Report*, n 1, 175.

[168] Grubb, n 108, 232; see, eg, *R v Hood* (2002) 130 A Crim R 473; [2002] VSC 123; *R v Maxwell* [2003] VSC 278.

[169] Otlowski, n 61, 10, cited in *Victorian Report*, n 1, 173.

Although there is no statutory protection of medical practitioners outside of South Australia, Queensland and Western Australia, the prosecution of a medical practitioner who hastens the death of a patient is rare. There are several reasons for this. First, for the offence of murder, the focus in on proving a medical practitioner's subjective intention. The Victorian Inquiry recognises that "[t]his is notoriously difficult to establish, particularly beyond reasonable doubt as is required in the criminal law setting".[170] A survey canvassing the administration of drugs at end-of-life in doses greater than those required to relieve symptoms concluded that it may be difficult to distinguish an intention to hasten death (36.2% responded that they had acted with such an intention[171]) from accepted palliative care, "except on the basis of the doctor's self-reported intention".[172] Second, authorities and Coroners are reliant on the matter being reported to them before it can be investigated.[173] Third, in cases where it is alleged that a medical practitioner has hastened the death of a patient, the inherent evidentiary challenge in a criminal proceeding is that the medical practitioner under investigation cannot be compelled to give evidence. Fourth, the best witness is dead.

AN ALTERNATIVE APPROACH IS REQUIRED

In the deserving case, an alternative approach is required to release a medical practitioner from criminal liability for murder (or manslaughter). As has been achieved in Queensland, South Australia and Western Australia, the remaining States and Territories could similarly enact legislative protection. A proposed provision is:

(1) A medical practitioner responsible for the palliative care of a person in the terminal phase of a terminal illness, or a person participating in such care under the medical practitioner's supervision, or a person providing such care at the medical practitioner's written order, incurs no criminal liability by administering, not administering or ceasing to administer such care to a person with the intention of relieving pain or suffering –
    (a) with the consent of the person or the person's representative; and
    (b) in good faith; and
    (c) with reasonable care and skill in accordance with the proper professional standards of palliative care,

if administering, not administering or ceasing to administer such care is reasonable, having regard to the person's state at the time and all the surrounding circumstances of the case, even though an incidental effect is to cause or hasten the death of the person.

(2) Subsection (1) does not authorise an act done or an omission made for the purpose of causing or hastening the death of the person to whom such care is administered, not administered or ceased.

Otherwise, the legal evaluation of circumstances where proper medical treatment incidentally shortens life remains an undeveloped area of the common law. However, the apparent irreconcilability of orthodox criminal law principles[174] with the deserving case of a medical practitioner who administers a lethal dose of medication with the intention to relieve pain may well be a matter of not seeing the forest for the trees. In *R v Crabbe* the Court said in obiter that "[a]cademic writers have pointed out that in deciding whether an act is justifiable its social purpose or social utility is important".[175] Noting that "[o]ne cannot be both acting recklessly and acting justifiably",[176] this, of course, is a question to be judicially determined.

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[170] *Victorian Report*, n 1, 116.

[171] Douglas et al, n 65, 513.

[172] Douglas et al, n 65, 511.

[173] *Western Australian Report*, n 1, 209; see also J Griffiths, "Euthanasia and Assisted Suicide Should, When Properly Performed by a Doctor in an Appropriate Case, Be Decriminalised" in A Alghrani, R Bennett and S Ost (eds), *Bioethics, Medicine and the Criminal Law: Volume 1: Part I: Death, Dying and the Criminal Law* (CUP, 2012) 21.

[174] JC Smith, *Justification and Excuse in the Criminal Law* (Stevens and Sons, 1989) 64–70; Ashworth, n 95, 153.

[175] *R v Crabbe* (1985) 156 CLR 464, 470 (Gibbs CJ, Wilson, Brennan, Deane and Dawson JJ).

[176] M Goode, "Fault Elements" (1991) 15 Crim LJ 95, 105.

CONCLUSION

It has been identified that, in the context of palliative care, uncertainty about the law leads health practitioners to fear prosecution, and a fear of prosecution has the potential to impair the proper pain management of the palliated patient. An issue identified is the lack of clarity surrounding the operation, status and application of the doctrine of double effect. The doctrine distinguishes between intended effects and unintended but foreseen side-effects and holds that under certain conditions it is ethically permissible to cause the death of another person. It is applied in the practice of palliative care to justify the double effect of causing or hastening the death of a patient when this is an incidental effect of administering medication to relieve pain and suffering. The doctrine has work to do in the rare circumstance that a patient's pain is unable to be controlled and increasingly large doses of medication are required with the probable consequence of hastening death.

The case of *R v Bodkin-Adams* – although not couched in terms describing the doctrine – stands as authority for the recognition of the doctrine at common law. However, to date in Australia there is no case that squarely deals with question of whether the act of a medical practitioner who administers a lethal dose of medication with the intention to relieve pain while foreseeing the medication will probably cause or hasten the death of his or her patient is justifiable. In most jurisdictions, the fault element for murder (manslaughter in the Northern Territory) includes recklessness. Therefore, the doctrine cannot avoid criminal liability being established in the face of orthodox criminal law principles.

At common law there is room to find that a medical practitioner who administers a lethal dose of medication is lawfully justified in doing so by applying the considerations adverted to in *R v Crabbe,* namely a two-stage enquiry where the social purpose of such an act "may bear on whether the act is justifiable".[177] However, at this point the subsidiary question of evaluating the social purpose or utility of behaviour where the fault element for murder is established has not been addressed. Hence, at common law, a result relieving a medical practitioner from liability is uncertain. Although the prosecution of medical practitioners is rare, it remains a live issue. Therefore, the enactment of legislation, as has occurred in Queensland, South Australia and Western Australia, is the means to achieve the certainty sought.

[177] Goode, n 176, 105; see also C Howard, *Criminal Law* (Lawbook, 3rd ed, 1977) 55–56, 367–369; B Fisse, *Howard's Criminal Law* (Lawbook, 5th ed, 1990) 491–493; S Yeo, *Fault in Homicide* (Federation Press, 1997) 84.