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The Care of Terminally-ill Patients Bill 2002 (Qld): Clarifying the Right of Medical Practitioners to Administer Treatment

The Care of Terminally-ill Patients Bill 2002 (Qld), a Private Member's Bill, is intended to remove the threat of prosecution under the Criminal Code *from doctors who administer medication to patients who are dying, without the intention of shortening the patient's life, but where the patient does in fact die sooner as a consequence of being given the medication.*

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1 INTRODUCTION

The Care of Terminally-ill Patients Bill 2002 was introduced into the Legislative Assembly as a Private Member's Bill on 19 June 2002 by Peter Wellington MP, the Independent Member for Nicklin. In introducing the Bill, the Member stated that the objective was to remove the threat of prosecution under **s 296** *Criminal Code* from doctors who administer medication to patients who are dying, without the intention of shortening the patient's life, but where the patient does in fact die sooner as a consequence of being given the medication.[1]

The Bill does not provide for the legalisation of euthanasia or assisted suicide; it only ensures that medical practitioners treating terminally ill patients will not be subject to prosecution if the treatment administered was unintentionally a causal factor in the death of the patient. In so doing, the issue of pain relief is being separated from the controversial issue of assisted suicide.

A current Justice of the Australian High Court once summed up the need for legislation on issues of ethics and morality concerning life and death in the following way:

> *Certainly, it is arguable that the failure to give nourishment, or the failure to provide a routine operation or the failure to give a shot of penicillin fall within the legal definition of murder, provided the requisite intention exists. It may be unreasonable to doctors to expose them, unguided by society, to accusations of murder. But it is equally unsatisfactory that decisions of this kind made by doctors should be left to the vicissitudes of unstructured moral determinations varying from individual to individual and from hospital to hospital: made without any guidance at all or, at best, with the help only of a closed hospital committee or appeals to the traditional medical way of doing things.*[2]

The material contained on the two Internet sites recommended by Mr. Peter Wellington MP: (www.preciouslegacy.com/chap11.html and www.saintmarys.edu/~incandel/doubleeffect.html) is reproduced in **Appendices A** and **B** to this Research Brief.

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1 Peter Wellington MP, Care of Terminally-Ill Patients Bill 2002 (Qld), Second Reading Speech, *Queensland Parliamentary Debates*, 19 June 2002, pp 1874-76.

2 Michael Kirby, *The Euthanasia-Living Will Debate*, The Australian Law Reform Commission, November 1981, pp 8-9.

2 THE NATURE OF PALLIATIVE CARE

Palliative care is a style or philosophy of care which assists a person with an advanced incurable illness to maintain as much independence and control as the progress of the illness will allow.[3]

Queensland Health has formally adopted the following definition of palliative care:

> *Palliative care is the active total care of those people whose disease is not responsive to curative treatments. Control of pain, of other symptoms and the need to address psychological, social and spiritual problems is paramount. The goal of palliative care is to achieve the best quality of life for patients and their families. Many aspects of palliative care can be applied earlier in the course of illness, in conjunction with treatment. The provision of hospice and palliative care services includes grief and bereavement support for the family and other carers during the life of the patients/clients, and continuing after death with the family.*[4]

The goal of palliative care is not to cure, but to provide comfort and maintain the highest possible quality of life for as long as life remains.[5] The provision of palliative care for terminally ill patients is increasingly being provided by palliative care professionals. It is care that is given to patients with life-limiting conditions, directed toward the easing of suffering and support in 'life closure' as opposed to treatment that is directed towards cure. Pain management is just one aspect of the more general specialty called palliative care. Top-quality palliative care containing pain management can mean the difference between a gentle death and one in which there is a high level of suffering.

The location at which the palliative care is delivered is irrelevant as the patient may be in a registered medical institution such as a hospital, a hospice or nursing home or even in their own home environment.[6] In fact, a fundamental principle of palliative care philosophy is that the service should ideally be delivered in the setting chosen by the patient.[7] Advances in medical technology have resulted in a blurring of the distinction between treatment that is directed at the underlying disease and treatment directed at the relief of suffering at the end of life.[8]

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3 Sharon Wiley, *Who cares for family and friends?: providing palliative care at home*, http://www.clininfo.health.nsw.gov.au/hospolic/stvincents/stvin98/a2.html Downloaded 24 July 2002, p 3.

4 Queensland Health. *Palliative Care Program Guidelines*, 2001, p 3.

5 *Palliative Care*, http://www.growthhouse.org/palliat.html Downloaded 23 July 2002.

6 Helen L. Smits, Maureen Furletti, Bruce C. Vladeck, *Palliative Care: An Opportunity for Medicare*, Institute for Medicare Practice, Mount Sinai School of Medicine, http://www.capcmssm.org/content/177/177.PDF Downloaded 23 July 2002, p 1.

7 Queensland Health. 2001, p 3.

8 Smits, Furletti, & Vladeck, p 2.

Within the medical profession, there is a distinction drawn between palliative medicine which is restricted to services provided by medical practitioners and other health professionals and palliative care which includes the broader array of services provided by the full interdisciplinary team including nurses and social workers.[9]

3 PALLIATIVE CARE UNDER THE AUSTRALIAN HEALTH CARE AGREEMENTS

The palliative care program commenced in June 1994 with Australia-wide funding of $55 million over 4 years. This level of funding was distributed to the States and Territories on a per capita basis. This program was replaced by the National Strategy for Palliative Care. The National Strategy for Palliative Care 1998-2003 is a commitment on the part of the Commonwealth, the States and Territories for the delivery of quality palliative care to those in need and was incorporated within the Australian Healthcare Agreements.

The Commonwealth Budget for 2002-2003 provided for the expenditure of $55 million nationally between 2002/03 and 2005/06 on palliative care in the community to be spent on supporting families and people who make a conscious decision to die in their own homes.[10] The National Strategy encompasses the following goals:

- Awareness and understanding on the part of the community and professionals of the role of palliative care practices; and
- Continual improvement in the quality and effectiveness of palliative care delivery; and
- The promotion of partnerships in the provision of care for the dying and their families.[11]

In Queensland the Palliative Care Program is funded annually to a level of $10 million. The program consists of equal contributions from the State and Commonwealth which are allocated to the three Health Zones and then subsequently to the Health Districts that are located within the respective zones.

The Southern Zone contains 10 health districts, the Central Zone has 13 districts and the Northern Zone has 11 districts. The funding guidelines for the respective health districts were developed by Queensland Health in 1999. Population and funding statistics for each of the health districts are listed in **Appendix D** of this Research Brief.

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9 Smits, Furletti, & Vladeck, p 2.

10 Australia. *Budget Measures 2002-03,* Budget Paper No 2, p 118.

11 Australia. Commonwealth Department of Health and Aged Care, *National Palliative Care Strategy: A National Framework for Palliative Care Service Development,* October 2000, p 8.

There is a definite trend toward more palliative care being provided within the home environment. For instance, the St Vincent's Community Service in Bundaberg has experienced an increase in demand for palliative care within the home as part of the home nursing service.[12]

4 THE DIFFERENT PERSPECTIVES OF LAW AND ETHICS

It is arguable that, when considering legislation dealing with the process of dying, members of parliament are delving into the very essence of the relationship between law and morality.[13]

Law and ethics are not the same in relation to the topic of human life. Some actions may be defensible from an ethical point of view without being condoned under legal provisions. It is arguable that law only contains a minimal level of ethics because law reflects the values of society at large which by definition is a social consensus on any particular issue.[14]

Legal provisions impose limits on decisions that may be ethically sound but carry a risk to life. In doing so, they provide a framework to guide certain decisions or practices. A realistic framework provides legal provisions indicating the requirements that need to be fulfilled by medical professionals in the treatment of their patients in order to avoid liability for the consequences of that treatment.[15]

The rationale underlying the Care of Terminally-Ill Patients Bill 2002 was described in the following way:

> *…many Queensland doctors hold back from prescribing enough medication to effectively relieve pain in the terminally ill, because under present state law they could be prosecuted if their patient dies as a consequence of their action. This in turn causes many people with terminal illness to spend their final moments in acute agony and causes intense distress to their loved ones. This Bill, I believe, will redress this problem.*[16]

It has been argued that that there are four basic principles of therapeutic intervention in palliative medicine that should be universally adopted:

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12 'Demand up for palliative care', *The Catholic Leader*, 14 July, 2002, p 17.

13 Don Stewart, 'Legislation, Ethics and Social Policy: The Case of Dying with Dignity,' in John Morgan (ed), *An Easeful Death?: Perspectives on Death, Dying and Euthanasia*, Federation Press 1996, pp 160-171, p 160.

14 *Ethics and Legal Issues in Palliative Care*, Department of Pain Management and Palliative Care, Beth Israel Medical Centre, http://www.stoppain.org/palliative_care/ethics.html Downloaded 23 July 2002, p 4.

15 *Ethics and Legal Issues in Palliative Care*, p 4.

16 Peter Wellington MP, Care of Terminally-Ill Patients Bill 2002 (Qld), Second Reading Speech, *Queensland Parliamentary Debates*, 19 June 2002, p 1874.

1. Care must be intended solely to relieve suffering; and

2. It must be administered in response to that suffering; and

3. It must be commensurate with that suffering; and

4. It cannot be a deliberate infliction of death.

Full treatment documentation must be kept in order to show that the above principles have been satisfied.[17]

The distinction drawn at law is between the intention to kill on the one hand and the intention to alleviate pain on the other. From a religious perspective, it is wrong to cause the death of another innocent human being but the doctrine of double effect is used to explain unintended consequences. The doctrine is used in the following way:

> *Provided there is a sufficiently grave reason for doing so, it is held to be morally permissible unintentionally to bring about a state of affairs (involving the infliction of harm) which, if it were produced intentionally, would be prohibited. A reason for permitting an unintended harm is considered grave enough when permitting it is necessary to bring about a proportionately good effect. As long as these twin requirements are satisfied, an agent is not responsible for harm that is unintentionally brought about, even when it is forseen that the harm will eventuate; by way of contrast, an agent is responsible for what is intentionally brought about, since that is a matter of choice. It should be noted that it has become customary in Catholic teaching to regard as intended not only the good that is aimed at but the means to achieve that good. So to bring about the death of an innocent human being as the means of achieving some good effect is considered a violation of the doctrine.*[18]

For the double effect principle to be invoked to provide moral support for the taking of an action, there are four necessary conditions that are to be met. Firstly, the action under consideration must be either morally good or morally indifferent; secondly, that the negative result is not intended; thirdly, that the positive result not be a direct causal result of the negative result; and fourthly, that the positive result be in proportion to the negative result. It is argued that, if all these conditions are met, then it is morally permissible for the action to be taken despite the negative effect.[19]

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[17] Michael Ashby, 'On Causing Death', *Medical Journal of Australia,* 175(10), 19 November 2001, pp 517-18, p 518.

[18] Robert Young, 'Death and Philosophy', in Allan Kellehear, (ed) *Death and Dying in Australia*, Oxford University Press, 2000, pp 330-41, p 332.

[19] Wm. David Solomon, *The Encyclopedia of Ethics*, www.saintmarys.edu/~incandel/doubleeffect.html Downloaded 5 August 2002.

The opposing argument is that the moral character of any action is specifically determined by the nature and extent of the resulting consequences. This approach is based on the premise that actions do not have a moral character independent of their consequences.[20]

The doctrine of double effect relies on a sharp distinction between intentions and consequences. Any intervention that is intended for a primary purpose that is positive, such as the relief of pain, is justifiable even in the face of unintended negative consequences, such as death. Such an effect (death) can even be anticipated as long as it was not intended that it occur.[21] However, the issue is not clear-cut as the following statement indicates:

> *Can a hastened death be truly described as 'unintended' and 'incidental' if clinical reasoning makes it foreseen, it is discussed with the patient and carers, agreed to, and then deliberately proceeded with?*[22]

Technology has afforded the opportunity to extend life significantly by artificial and mechanical means. However, technology is a two-edged sword as it provides full recovery for some but extends life beyond all hope for others. From a positive perspective, advances in drug technology have resulted in drugs that can induce death that is no more physically traumatic than falling asleep. The level of dosage of particular drugs can determine whether the result is the easing of pain and discomfort or the hastening of death.[23]

4.1 AN OPPOSING VIEW ON DISCOVERING INTENTION

There are those who argue that seeing the issue as one of determining intention on the part of the medical practitioner is not the answer. As one medical practitioner giving evidence to a Committee of the Victorian Parliament said:

> *… there are sound reasons as to why the law has traditionally regarded foresight as sufficient for intention. It is not only that it is sometimes difficult to draw the distinction between what an agent intends and what she foresees (one reason is that only the agent will be able to tell what she had on her mind), but also … that health care professionals in deliberately choosing one course of action rather than another are also deliberately choosing all the consequences of their actions: in other words, they are sometimes choosing a patient's death.*

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20 Wm. David Solomon, *The Encyclopedia of Ethics,* www.saintmarys.edu/~incandel/doubleeffect.html Downloaded 5 August 2002.

21 Alan Lieberson, *Treatment of Pain and Suffering in the Terminally Ill,* Chapter 11, http://www.preciouslegacy.com/index.html Downloaded 5 August, 2002, p 2.

22 Roger Hunt, 'Intention, the law, and clinical decision-making in terminal care', *Medical Journal of Australia*, 175(10), 19 November 2001, p 516.

23 Robin Tapley, pp 3-4.

> *So if the law is intended to protect patients against doctors unjustifiably bringing about their deaths, or unjustifiably allowing their deaths to occur, the question is not what a doctor has on her mind when she does what she does, but rather whether a doctor in deliberately bringing about one consequence rather than another is acting in accordance with the patient's rights and interests. The distinction between a doctor intending a patient's death and merely foreseeing that death will occur cannot provide the answer to that question.*[24]

4.2 AN ALTERNATIVE VIEW ON LAW CHANGES

It has been recently argued that other States should follow the lead of South Australia by passing legislation to provide protection from litigation to doctors where they provide pain relief for terminally ill patients, thereby hastening the onset of death.

The alternative law change envisaged is that a defence of 'justifiable murder' should be drafted into statutory provisions. However, this approach would still be founded on the intention of the doctor. The changes would create a new legal defence of good medical practice:

> *Doctors will obviously find this uncomfortable because we're saying "yes you're murdering, but it's okay"… It's better to admit that you are intentionally causing death, but then say it's an acceptable form of hastening death.*[25]

The Australian Medical Association (AMA) responded to this suggestion by saying that it would oppose any amendments along this line:

> *It sounds like a very sophisticated pro-euthanasia argument.*[26]

This suggested approach has not been incorporated into the Care of Terminally-Ill Patients Bill 2002 now before the Legislative Assembly as an intention to cause death would still leave doctors criminally liable.

5 VIEWS OF THE AUSTRALIAN MEDICAL ASSOCIATION

The AMA has published a position statement on the care of severely and terminally ill patients. Two important clauses of the AMA's statement are:

1.1 The AMA believes that doctors should not be involved in interventions that have as their primary goal the ending of a person's life.

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[24] Victorian Parliament, Social Development Committee, *Report upon the Inquiry into Options for Dying with Dignity*, Second and Final Report, No 19 1987, p 131.

[25] John Kron, 'justifiable murder defensible', *Australian Doctor,* 19 July 2002, p 12.

[26] John Kron, p 12.

2.1 The AMA endorses the right of a patient to refuse treatment and the right of a severely and terminally ill patient to have relief of pain and suffering, even when such therapy may shorten that patient's life.[27]

The position statement also supports the World Medical Association's *Declaration on Euthanasia* which states that euthanasia and doctor assisted suicide are unethical but that the right of competent patients to be autonomous regarding the management of their medical condition must be upheld by doctors.[28]

Clause 2.1 (above) was amended earlier this year when the executive of the AMA resolved at its annual meeting to express support for doctors who give terminally Ill patients pain relief despite a possible secondary effect of hastening death.[29]

6 ISSUES OF CONSENSUS

A high level of pain suffered at the end of life can be eliminated by the provision of a standard of palliative care but unacceptable suffering can still occur in the face of excellent palliative care with the result that some patients who suffer in this way will want to escape from what they feel is an intolerable situation. This leads to the identification of common issues that can be identified between supporters and opponents of euthanasia and those who are supportive of palliative care in its own right:

- A central goal of medicine is to relieve suffering by helping people die with comfort, support and meaning.
- Comprehensive, interdisciplinary palliative care is the standard of care for persons with progressive, advanced disease for whom the prognosis is limited and the focus of medical management is quality of life.
- Medical practitioners must provide adequate pain relief according to well-established standards.
- Patients have the right to refuse unwanted treatment or to stop treatment once it has started.
- Patients who request that death be hastened – by the foregoing of life-sustaining therapy, the voluntary cessation of eating and drinking, terminal sedation, assisted suicide, euthanasia

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27 Australian Medical Association, 'Care of Severely and Terminally Ill Patients', *Position Statement:*http://domino.ama.com.au/AMAWeb/Position.nsf/2450dc7198e39dd84a2568ea0045ca07/07a85805e266a6994a2565e000023b21?OpenDocument Downloaded 1 August 2002.

28 Australian Medical Association, Clause 1.6

29 John Kron, 'Justifiable murder defensible', *Australian Doctor*, 19 July, 2002, p 12.

should have their requests fully explored and they deserve an exhaustive search of palliative alternatives.

- Even if assisted death is justified under some exceptional circumstances, this does not necessarily mean that it should be supported by public policy.
- Every medical practitioner should remain committed to the skilful and compassionate care for the terminally ill throughout the dying process but should not be required to violate his or her own fundamental values.[30]

The development of good public policy about assisted death requires a genuine commitment to end of life care within a medical and legal framework which allows the amelioration of suffering. From a public policy perspective, there is a need to recognise that there is a strong area of disagreement about the management of a relatively small number of patients for whom the best and most comprehensive palliative care becomes ineffective.[31] It is also important to recognise that a transient wish to die is common among the terminally ill but very few of them have a clear, persistent wish to die.[32]

7 THE EMOTIONAL IMPACT ON MEDICAL STAFF

The Netherlands recently passed legislation allowing medical practitioners, upon request, to end the life of terminally ill patients.[33] Belgium has also recently passed legislation under which patients wishing to end their lives may request euthanasia. Their doctor must complete a form and consult another physician before making a final decision.[34] The effect on the emotions of the Dutch medical profession of end-of-life decision making was surveyed in 1996 before the legislation was passed in 2001. Just over 400 Dutch doctors were interviewed on their involvement in euthanasia, assisted suicide, the ending of life without an explicit request from the patient and the alleviation of pain with high does of medication that carried a risk of shortening the patient's life. The interviews contained questions designed to ascertain the emotions of the doctors with respect to later doubts or regrets as to their involvement in cases involving end-of-life matters. Table 1 indicates the responses received.

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30 Timothy Quill, Diane Meier, Susan Block, Andrew Billings, 'The Debate over Physician-Assisted Suicide: Empirical data and Convergent Views', *Annals of Internal Medicine*, vol 128, 1 April 1998, pp 552-558: http://www.acponline.org/journals/annals/01apr98/pasdebat.htm Downloaded 29 July 2002.

31 Quill, Meier, Block & Billings, p 8.

32 Quill, Meier, Block & Billings, p 3.

33 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001* (Netherlands)

34 'Belgium adopts law on mercy killing', *Courier Mail*, 25 September 2002, p 18.

Table 1[35]

Doctors' feelings after their most recent case of end-of-life decisions

Type of end of life decision	Feelings of comfort (Yes)	Feelings of comfort (No)	Feelings of discomfort (Yes)	Feelings of discomfort (No)
Euthanasia	52%	48%	75%	25%
Assisted suicide	63%	37%	58%	42%
Ending of life without specific request from patient	56%	44%	34%	66%
Alleviation of pain and distress	48%	52%	18%	62%
Shortening life: by more than one month	36%	64%	86%	14%
One to four weeks	59%	41%	47%	53%
Less than seven days	52%	48%	29%	71%
Degree of suffering: Extreme	63%	37%	67%	33%
Unbearable	51%	49%	76%	24%
Moderately severe	36%	64%	77%	23%
Intention: Hastening death was partially the intention	54%	46%	19%	81%
Hastening death was explicit intention	32%	68%	28%	72%

In the Dutch survey, where end of life hastening medication had been administered with the primary aim of symptom relief only, 18% of the doctors responding to the survey reported having feelings of discomfort. In such circumstances, the doctor does not feel a strong sense of agency in the death of the patient. Whereas on the other hand, the more a doctor perceives that he or she has been an active participant in the death of a patient, the more there will be emotional upset.[36]

In 1999 a survey was conducted among a sample of 992 Australian surgeons to ascertain attitudes to assisted death. Of the 683 respondents, 247 reported that for the purpose of

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35 Llinka Haverkate, Agnes Van der Heide, Bregje Onwuteaka-Philipsen, Paul van der Maas, Gerrit van der Wal, 'The emotional impact on physicians of hastening the death of a patient', *Medical Journal of Australia*, 175(10), 19 November 2001, pp 519-22, p 521 (Box 2).

36 Christopher Ryan, 'When our patients die', *Medical Journal of Australia*, 175(10), 19 November 2001, pp 524-525, p 524.

relieving a patient's suffering, they had given drugs in doses that they perceived to be greater than those required to relieve symptoms with the intention of hastening death. The authors of the study concluded that the doctors who responded affirmatively to this question had crossed a legal threshold and perhaps a moral threshold also. Legal and moral distinctions based solely on a doctor's intention are problematic because the act of administering drugs is difficult to distinguish from acceptable palliative care in the absence of any self-reported intention on the part of the doctor concerned.[37]

The administering of drugs in quantities greater than that required for the control of pain and symptoms in patients can be seen as exhibiting an intention to hasten death. However, medical practitioners can administer potentially lethal drugs to terminally ill patients to treat symptoms whilst at the same time foreseeing, without necessarily intending, that an earlier death should result.[38]

In response to a question as to whether or not they would administer drugs to a patient in whatever dosage necessary to keep the patient comfortable even if this would incidentally hasten death, 641 (93%) of the responding doctors answered affirmatively.[39]

The emotions that are highlighted by the above survey are not unique to medical practitioners as nursing staff and social workers, who are also important players in the provision of palliative care of the dying, are also open to similar feelings:

> *…nurses go through the same…stages of grief that their dying patients experience.*
>
> *…suggestions for helping the grieving nursing staff replenish their emotional reserves after the death of a patient so that they can continue to give the kind of support other dying patients need.*[40]

8 KEY PROVISIONS OF THE CARE OF TERMINALLY ILL PATIENTS BILL 2002 (QLD)

The Bill is founded in the belief that terminally ill patients have a right to compassionate care that respects their dignity.

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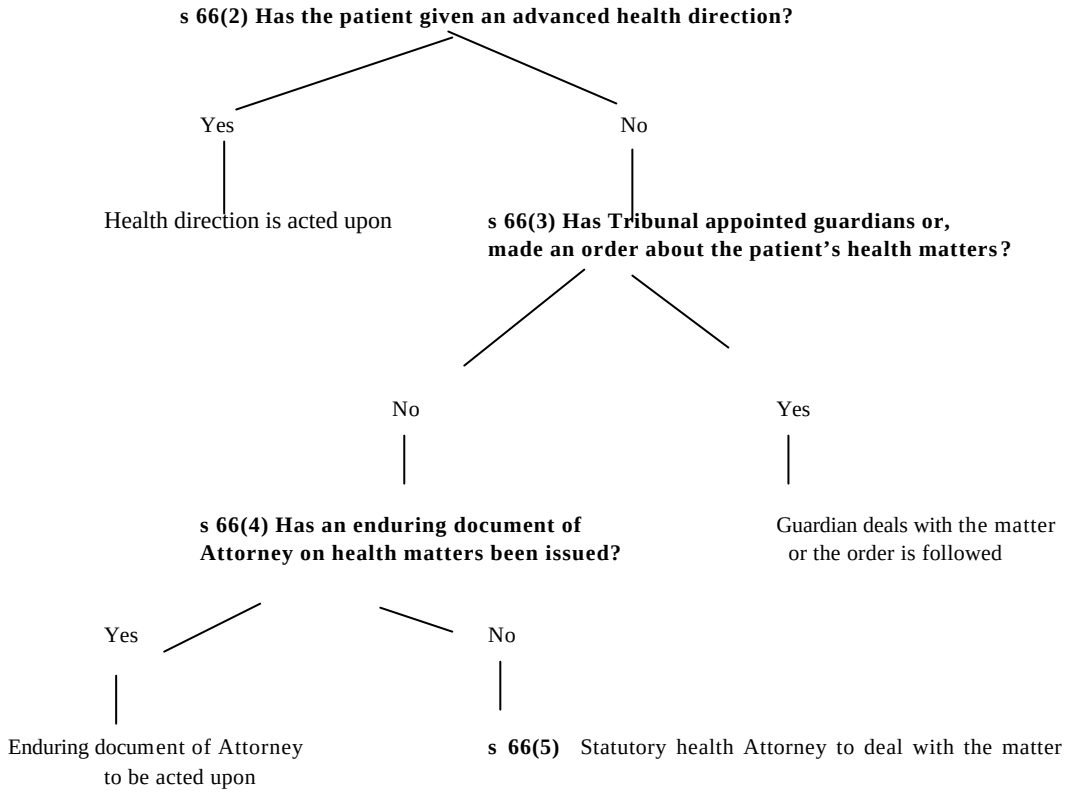
37 Charles Douglas, Ian Kerridge, Katherine Rainbird, John McPhee, Lynne Hancock, Allan Spigelman, 'The intention to hasten death: a survey of attitudes and practices of surgeons in Australia', *Medical Journal of Australia,* 175(10), 19 November 2001, pp 511-515, p 511.

38 Douglas, Kerridge, Rainbird, McPhee, Hancock & Spigelman, p 511.

39 Douglas, Kerridge, Rainbird, McPhee, Hancock & Spigelman, p 513.

40 Carol Germain, 'Nursing the Dying: Implications of Kubler-Ross' Staging Theory', *Annals of the American Academy of Political and Social Science,* (447), January 1980, pp 46-58, p 52.

Clause 2 provides for the administering of pain relieving drugs to terminally ill patients in amounts that may shorten the person's life, provided the patient has given his or her informed consent or, where the patient cannot do this, the health matter priorities listed in **s 66** of the *Guardianship and Administration Act 2000* have been followed. Under **s 66**, the process under which health matters of a patient who can not give informed consent are to be dealt with are represented in the following flow chart:



Clause 3 provides that no liability will accrue to medical practitioners or any person under a medical practitioner's supervision where medical treatment has been provided which shortened the life of the patient when the treatment was administered for the relief of pain and where the treatment was administered:

- in good faith and without negligence; and
- **clause 2** was complied with, and
- the treatment accorded with professional standards of palliative care.

Put specifically, **clause 3** provides a new statutory protection for doctors whose terminally ill patients die as a by-product of the administration of treatment aimed at relieving pain and suffering.

Clause 4 provides that the administration of treatment for the relief of pain or distress in accordance with **clause 3** is not to be regarded as constituting an intervening cause of death.

9 OTHER AUSTRALIAN JURISDICTIONS

9.1 SOUTH AUSTRALIA

Currently, South Australia is the only Australian jurisdiction to have passed legislation specifically excusing medical practitioners from prosecution when a terminally ill patient who is administered medication to ease pain and suffering subsequently dies as an unintended result: see the *Consent to Medical Treatment and Palliative Care Act 1995*. The passing of the legislation came after the tabling of two reports by the Select Committee of the House of Assembly on the Law and Practice to Death and Dying.[41]

The Committee reported on the extent of a doctor's duty toward a terminally ill patient in the following way:

> *The law is unclear as to exactly what the doctor is required to do to discharge his or her duty to the patient. Legal opinion available to the Committee states: " a doctor must never do anything actively to kill his patient, but he is not bound to fight for his patient's life for ever. His duty in this respect is to make reasonable efforts, having regard to customary practice and expectations, and in particular having regard to the benefit to the patient to be expected from future exertions".*[42]

The Select Committee recommended that the law in South Australia be amended to:

> *…provide that the provision of palliative care (as defined) reasonably administered without negligence and with informed consent to a terminally ill patient, not carry any criminal or civil liability even if it has the effect of shortening life*.[43]

This recommendation was based on evidence given to the Committee concerning the principle of 'double effect' which was argued in the following way:

> *Here there is administration of medication aimed at maintaining comfort for the patient, but having also the potential to cause death earlier than if it had not been used.*
>
> *This is sometimes discussed as the 'principle of double effect'. A patient may have severe pain and restlessness which is able to be controlled only through large doses*

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41 South Australia. House of Assembly, *Interim Report of The Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying,* 31 October 1991 (Parliamentary Paper 164/1991) and Second Interim Report dated 6 May 1992 (Parliamentary Paper 185/1992).

42 South Australia. House of Assembly, *Interim Report of The Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying,* 31 October 1991 (Parliamentary Paper 164/1991).

43 South Australia. House of Assembly, *Second Interim Report of The Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying,* dated 6 May 1992 (Parliamentary Paper 185/1992), 'Recommendations', p iii.

> *of narcotics and sedatives which cloud consciousness and impair other body functions to such an extent that the onset of death is accelerated.*
>
> *Such an occurrence is not often necessary; usually the modern techniques of pain management available to experienced palliative care teams are able to control pain without significantly impairing other body functions. But when it occurs, palliative care doctors risk being charged with the administration of a drug which caused death, and in circumstances where the maintenance of life was judged to be less important and secondary to concern for the comfort of the patient and assessed quality of that patient's life.*[44]

The Select Committee specifically examined the question of voluntary euthanasia, stating that it did not agree that existing laws should be amended to provide for medical assistance in dying:

> *The Committee rejects the notion that there is no moral distinction between letting someone die and bringing about that person's death. The concept of intent has always been crucial to the law as, for example, in the legal distinction between murder, manslaughter and accidental death.*
>
> *The Committee believes distinctions based on intent should be maintained in the law.*[45]

In introducing the Private Member's Bill into the Queensland Parliament, Mr Peter Wellington MP stated that the Care of Terminally Ill Patients Bill 2002 was neither a pro-euthanasia nor anti-euthanasia Bill.[46] Consequently the Bill can be seen, at most, as a legislative instrument that will allow doctors to improve the quality of the natural process of dying and not one that allows death to be viewed as a therapeutic tool of the medical profession.

Similarly, a member of the South Australian House of Assembly made the following observation during the debate on the Consent to Medical Treatment and Palliative Care Bill:

> *The select committee introduced the principle of double effect, which essentially is a structural paradigm which distinguishes palliative treatment from euthanasia. Essentially, this means that in terms of palliative treatment the primary intention or desired effect is the relief of suffering and that the hastening of death is regarded as an unintended or secondary effect. That is where it differs from euthanasia, and*

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44 South Australia. House of Assembly, *Second Interim Report of The Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying,* dated 6 May 1992 (Parliamentary Paper 185/1992) 'Introduction to the Report', p 8.

45 Professor Ian Maddocks, Foundation Professor of Palliative Care, Flinders University of South Australia; President of the Australian Association for Hospice and Palliative Care (written submission page 7), quoted in South Australia. House of Assembly, *Interim Report of The Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying,* Second Interim Report dated 6 May 1992 (Parliamentary Paper 185/1992), p 51.

46 Mr Wellington MP, Care of Terminally-Ill Patients Bill, Second Reading Speech, p 1874.

> *the select committee stopped short of recommending that we consider euthanasia at this time.*[47]

Section 17(1) of the South Australian Act provides that a doctor responsible for the treatment or care of a terminally ill patient does not incur civil or criminal liability if the act of administering treatment with the intention of relieving pain or distress also results in the hastening of the patient's death, provided the treatment administered was with the consent of the patient or patient's representative, was administered in good faith and without negligence, and was in accordance with professional standards of palliative care.

The South Australian legislation does not protect a medical practitioner who intentionally administers treatment to a terminally ill patient in order to hasten death with the relief of suffering as a secondary effect.[48]

9.2 VICTORIA

The Social Development Committee of the Victorian Parliament conducted an inquiry into options for dying with dignity. The Second and Final Report of the Committee was tabled in the Legislative Assembly in April 1987. This report contained 31 recommendations, one of which was the protection from criminal and civil liability of medical practitioners who act in good faith when complying with the wishes of a competent patient to withhold treatment.[49] This recommendation was enacted in **s 9** of the *Medical Treatment Act 1988*. However, the Committee did not recommend that a similar protection be afforded to medical practitioners who administer treatment primarily for the relief of pain and distress but which also results in the hastening of death.

10 DECISIONS OF THE UNITED STATES SUPREME COURT

In 1997 two appeal decisions were handed down by the Supreme Court.[50] The decisions showed that, in the opinion of Justices sitting on the highest court in the United States, State governments were able to enact legislation that distinguished between prohibiting conduct on the

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47 Ms Stevens MP, Member for Elizabeth, *South Australian House of Assembly Debates*, Second Reading Debate, Consent to Medical Treatment and Palliative Care Bill, 30 November 1994, p 1351.

48 Roger Hunt, 'Intention, the law, and clinical decision-making in terminal care', *Medical Journal of Australia*, 175(10), 19 November 2001, p 516.

49 Victorian Parliament, Social Development Committee, *Report upon the Inquiry into Options for Dying with Dignity*, Second and Final Report, April 1987, Recommendation 4.

50 *Vacco v Quill* 117 S Ct 2293 (1997); *Washington v Glucksberg* 117 S Ct 2258 (1997).

part of medical practitioners that would intentionally hasten death and conduct that may foreseeably hasten death but was intended for more important purposes such as pain relief.

The court accepted that the doctrine of double effect provided a rational and constitutional basis for States to allow medication to be given in high doses for adequate pain relief in terminally ill patients. Further, the concurring justices of the court suggested that the State was obliged to allow medical practitioners to provide adequate pain relief at the end of life even if unconsciousness and perhaps death were to be hastened. These two decisions of the court have been interpreted as establishing a right of pain relief that is closely allied with other personal rights such as a right to abortion or the right to refuse medical treatment.[51]

10.1 PAIN RELIEF PROMOTION ACT 1999

The terminal care v euthanasia debate in the United States culminated in the State of Oregon passing the *Death With Dignity Act 1997* which allowed for legalised physician assisted suicide. This piece of legislation was countered by the anti-euthanasia lobby in Washington when the *Pain Relief Promotion Act 1999* was introduced into the House of Representatives. The Federal Act promotes pain management and palliative care without permitting assisted suicide and euthanasia and in so doing identifies pain control as a priority for public health policy.[52]

The Federal Act is divided into two component parts – Part I dealing with the use of controlled substances and, Part II dealing with the promotion of palliative care services.

Critics of the Federal Act argued that focusing on the intention of the medical practitioners whose patients die whilst being treated could lead to medical practitioners curtailing their pain management practices, as medical practitioners could be asked to justify the medication regime that they administered to their deceased patients.

Opponents of the legislation argued that with the imposition of severe penalties combined with judgements being made on the intention of doctors after the fact, only courageous doctors would risk pursuing an aggressive and appropriate pain relief regime that supporters of the Act

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[51] Ann Alpers and Bernard Lo, 'The Supreme Court Addresses Physician Assisted Suicide: Can Its Rulings Improve Palliative Care', *Archives of Family Medicine*, http://archfami.ama-assn.org/issues/v8n3/ffull/fsa8017.html Downloaded 29 July 2002, p 2.

[52] Sandra Johnson, 'Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act', *Journal of Law, Medicine and Ethics*, 24 (1996), pp 319-327, p 326. http://www.aslme.org/pub_jlme/24.4d.html Downloaded 29 July 2002.

sought.[53] On the other hand, supporters of the legislation argued that it is a legislative instrument designed to promote the utilization of pain medication and not the legalisation of assisted death.

The Federal Act recognises that the alleviation of pain or discomfort is a legitimate reason for prescribing medication for terminally ill patients even if such action may increase the risk of death. The legislation also contains provisions regarding the education of health professionals in the use of controlled substances in pain management and palliative care.

11 CONCLUSION

The provisions of the Care of Terminally-Ill Patients Bill 2002 clearly do not provide legislative support for either the euthanasia or the anti-euthanasia movements. The Bill is concerned with lawfully removing the fear of criminal or civil liability from medical practitioners who provide treatment to terminally ill patients for the alleviation of pain and distress even if that treatment may have hastened the onset of death.

With over 80% of all deaths in industrialised countries being the end result of chronic illness and with 50% of the population dying of an illness that was diagnosed more than two years earlier,[54] the need for palliative care in all its recognised forms within the Australian and Queensland population will grow as the post-war population ages.

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[53] Patrick Leahy, Vermont's U.S. Senator, 'Pain Relief and Promotion Bill', *News Releases and Statements*, 27 April, 2000, http://leahy.senate.gov/text/press/200004/000427e.html Downloaded 29 July 2002.

[54] Robin Tapley, 'Good Death, Bad Death: Why a Doctor's Help in Dying Ought to be Permitted', *Policy Options*, December 1997, pp 3-5, p 3.

APPENDIX A - CHAPTER 11. DOUBLE-EFFECT AND PHYSICIAN ASSISTED SUICIDE

11.01 Double-Effect; Introduction

11.02 The Principle of Double-Effect

11.03 Historical/Religious Development

11.04 Ethical Considerations

11.05 Legal Considerations

11.06 Clinical Effects

11.07 Double-Effect Versus Euthanasia

11.01 Double-Effect; Introduction

Slowly in the course of a terminal illness the body weakens and its reserves dwindle. Frequently as this happens the mind becomes less active and less tormented -- more accepting of the reality of death. At the same time, pain and other symptoms may also decrease, and the last few days of life may be totally devoid of significant suffering up until the time, as usually happens, the patient falls into a deep sleep or coma which quietly precedes death.

At other times, however, death is not so benevolent. Pain and other symptoms like nausea and shortness of breath may continue and even get worse requiring increasing medical intervention to obtain relief. When this happens, physicians are forced to make a difficult decision -- as body strength falters it becomes less and less tolerant of high doses of drugs, but as pain and suffering increase, adequate treatment requires ever increasing amounts of medication. Eventually a point is reached at which further increases in drug dosages to adequately control pain or other symptoms may be beyond the limit of body tolerance and could easily result in death.

The question this dilemma raises is when does the known risk of death from giving medications sufficient to control symptoms become potential manslaughter if death should occur? This chapter on the theory of "double-effect" discusses this issue. In reading the chapter it is important to keep in mind the use of the double-effect theory almost always relates to a situation involving an end-stage terminal illness at a point in time when essentially everyone involved in the patient's care has accepted that death is no longer the patient's enemy, but would be a welcomed, if not sought after, event.

It is also well to keep in mind how common double-effect therapy is in the last few days of life. In the Netherlands, where euthanasia has been practiced openly for years, a recent very well researched report noted less than four percent of deaths occurred as a result of active euthanasia, but 17.5% were probably hastened by the giving of drugs to relieve terminal suffering.

11.02 The Principle of Double-Effect

"Double-effect" has been defined as "the administering of opioids or sedative drugs to relieve pain and suffering in a dying patient with the incidental consequence of causing either respiratory depression or extreme sedation or both, resulting in the patient's death."

For an action leading to a patient's death to be held to be both ethical and moral based on this concept, it must conform to the following four legal requirements:

1. the action itself must be good or indifferent;
2. the good effect and not the evil effect must be the one sincerely intended by the agent;
3. the good effect must not be produced by means of the evil effect; and,
4. there must be a proportionate reason for permitting the foreseen evil effect to occur.

Applying these requirements to the situation of the suffering, terminally ill patient:

1. the action must be undertaken with a reasonable chance of reducing pain and/or suffering;
2. the action must be primarily intended to relieve pain and suffering, not to produce death;
3. the action cannot be undertaken with the intent of producing death as a means of achieving relief from pain and suffering; and
4. there must be enough reason to undertake the action, such as increasing the dosage of morphine as needed to control pain, to risk the foreseeable chance of producing death.

The general principle of "double-effect" therapy was well summarized by Dr. Timothy Quill in a 1995 article in the Archives of Internal Medicine entitled "You Promised Me I Wouldn't Die Like This! A Bad Death as a Medical Emergency":

> *The doctrine of double effect relies on a sharp distinction between intentions and consequences. Interventions that are intended to have a "good" primary purpose, such as the relief of suffering, can be justified even if they have unintended "bad" consequences, such as contributing to a patient's death. Such bad effects can even be anticipated as long as they are not intended. This distinction has freed physicians to provide high doses of opioid analgesics to patients who are dying in pain, even if this intervention indirectly contributes to an earlier death. In practice, one can frequently find a pain regimen that provides sufficient relief without compromising the patient's consciousness of life span, but here again data are lacking. Double effect has recently been extended to treat patients who are tormented in dimensions other than pain. The primary intent of this intervention is to relieve suffering, and the sedated patient is then allowed to die of his or her disease, the barbiturates, pneumonia, and/or dehydration since he or she can no longer eat or drink. To remain within the confines of the*

> *double effect, death in these extreme circumstances may be foreseen, but must not be intended.*

To keep double-effect therapy within medically accepted boundaries, one must be able to say the patient died from a disease and not from the intended effects of the medication. It must be a rational statement to say death occurred as the result of the combined physical effect of the disease process and the medications which were required to treat the disease.

Although double-effect therapy is often considered to be quite different than other therapies because of ethical and legal considerations, it is not very different medically. Whenever a medical intervention is undertaken, there is always some identifiable and foreseeable risk to the patient, and often at least a minimal risk to the patient's life. In every case, the physician is expected to evaluate the risks and benefits of treatment, to recommend a course of treatment, and to provide treatments chosen by the patient or a surrogate speaking for the patient.

Thus, in a sense, the principle of double-effect comes into play every time a clinician chooses an antibiotic or chemotherapy regimen and weights the desired outcome against predictable toxicity; every time a surgeon and patient discuss the pros and cons of extensive surgery, life-threatening or not. Looked at in reverse, double-effect therapy is no different from any other medical therapy, the only difference being it is undertaken in a situation in which the risk of death is high but the risk worth taking because death is close at hand and in the absence of symptom control, there will be no pleasure in life prior to its occurrence.

11.03 Historical/Religious Development

The concept of double-effect can be found in the writings of Hippocrates, but is generally traced back to Aristotle through the thirteenth century teachings of St. Thomas Aquinas who invoked the principle of double-effect to justify a killing in self-defense. In his discussion, Aquinas stated: "The act of self-defense may have two effects, one is the saving of one's life, the other is the slaying of the aggressor. Therefore, this act, since one's intention is to save one's own life, is not unlawful." If, however, the act was undertaken with the intention of taking the other's life, the description of the act could no longer be one of "self-defense" but rather one of "killing." St. Thomas then went on to say that even if an individual foresees the appropriate force used in self-defense will definitely result in death, this would not imply the individual's intention, and therefore it would not be a killing.

More recently the Catholic Church has applied the concept of double-effect to medical care, the classic case being one in which a pregnant woman develops cancer of the uterus. In this situation the death of the unborn child resulting from the performance of a hysterectomy is held not to be a killing under the theory of double-effect as long as the four usual limitations are fulfilled. First, the action causing the dual effect must be good -- the removal of a cancerous uterus saves the life of the mother. Second, the good effect must not be obtained by means of the evil effect -- in this case, saving the mother is not the direct result of ending the life of the unborn child. Third, sufficient reason exists for permitting the unsought evil effect -- in this case, saving the life of the mother justifies the unavoidable death of the child.

Fourth, the evil effect is not intended in itself, but is merely allowed as a necessary consequence of the good effect -- the object is not to kill the child but to save the mother.

In applying these principles to the question of double-effect therapy to the treatment of the terminally ill patient, the 1994 Catechism of the Catholic Church in § 2279 reads:

Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.

11.04 Ethical Considerations

The religious formulation of the rational for double-effect therapy is closely followed by medical ethicists, again listing the necessary limitations as requiring that (a) the action is good in itself; (b) the intention of the act to be solely to produce the good effect; (c) the good effect is not achieved through the bad effect; and (d) there be sufficient reason to permit the bad effect.

As in the religious considerations, the ethical validity of the principle of double-effect requires a close look to insure the proper primary intent of the action because of the ethically significant distinction between foreseeing a potential undesired effect and intending an unavoidable maleficent outcome.

This difference between intended and unintended but foreseen consequences of medical treatment was well addressed by the first President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment in 1983 which concluded the relevant moral issue "is whether or not the decision makers have considered the full range of foreseeable effects, have knowingly accepted whatever risk of death is entailed, and have found the risk to be justified in light of the paucity and undesirability of other options."

11.05 Legal Considerations

Theoretically, the "double-effect" doctrine may conflict with the usual legal definitions of reckless homicide or involuntary manslaughter, which could lead to prosecution of the physician if he or she was held to have consciously disregarded "substantial and unjustifiable risk to human life." Fortunately, the legal system in every state in America has refused to take this approach and has uniformly accepted the concept of double-effect therapy.

Some states, including Indiana, Iowa, Kentucky, Michigan, Minnesota, Ohio, Rhode Island, South Dakota, Tennessee and Washington specifically mention it in their statutes, while others, including Maine, New Mexico, South Carolina, and Virginia specifically permit patients to sign health-care directives in which they authorize pain treatment even if it hastens death. In the remaining states, the same acceptance of double-effect therapy as relieving physicians from prosecution has been routinely upheld, even in

the case of Dr. Jack Kevorkian, whose lawyer argued his intent in assisting "his" patient's suicides was to relieve suffering -- death being a necessary collateral consequence.

The question of double-effect therapy has produced some interesting comments in the legal literature. In a famous Dutch case referred to as the "Postma decision," the court found a woman guilty of killing her mother when doses of narcotic intended to relieve her pain were all given at once with the intent of causing her death even though the mother was terminally ill. The court said if the doses had been given as ordered to relieve pain and the mother had died, the woman would not have been guilty of any wrongdoing.

In the recent U.S. Supreme Court decisions involving physician assisted suicide, the Court clearly differentiated and essentially approved the double-effect principle noting "when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain."

The New York Task Force set up by then Governor Cuomo in a report under the title: "*When Death is Sought*," stated: "It is widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death, if the medication is intended to alleviate pain and sever discomfort, not to cause death."

Finally, the Select Committee On Medical Ethics of the British House of Lords addressed the question of the need to rely on physicians to determine the intent of giving medication with the following statement:

> *In the small and diminishing number of cases in which pain and distress cannot be satisfactorily controlled, we are satisfied that the professional judgment of the health care team can be exercised to enable increasing doses of medication (whether of analgesics or sedatives) to be given in order to provide relief, even if this shortens life. The adequate relief of pain and suffering in terminally ill patients depends on doctors being able to do all that is necessary and possible. In many cases this will mean the use of opiates or sedative drugs in increasing doses. In some cases patients may in consequence die sooner than they would otherwise have done, but this is not in our view a reason for withholding treatment that would give relief, as long as the doctor acts in accordance with responsible medical practice, with the objective of relieving pain or distress and with no intention to kill.*

11.06 Clinical Effects

The acceptance of the concept of double-effect has freed physicians to provide high doses of narcotic pain relievers to patients who are dying in pain, even if this intervention indirectly contributes to an earlier death. In medical practice the physician can usually find a therapeutic pain-relief regimen which provides sufficient relief without compromising the patient's consciousness, but it is not always possible and it is certainly unpredictable. If the physician had reason to worry each time a large dose of narcotic was given to a weakened patient, his or her ability to control pain and other symptoms would be very compromised.

Although double-effect therapy is most frequently considered when dealing with pain, it has recently been extended to treat patients who are tormented in other dimensions as well. As long as the primary intent of the intervention is to relieve suffering, whether the suffering is in the form of pain, shortness of breath, nausea, or any other form, it doesn't matter. Morally, ethically, legally and medically, whether the patient dies of his or her disease, the medications, pneumonia, and/or dehydration since he or she can no longer eat or drink, it is considered to be death by natural causes. All that is required is that the physician remain within the confines of intending the relief of suffering and not death itself -- death in these extreme circumstances may be foreseen, but must not be intended.

11.07 Double-Effect Versus Euthanasia

Some commentators suggest double-effect theory is just a charade for euthanasia, used purely to legitimize the prevalent use of excessive morphine which is administered by physicians who know or suspect it will cause death. At times, as in the case of Dr. Kevorkian, it is hard to argue with this opinion, but many physicians say this is fine. They suggest that although they are antagonistic to legalizing euthanasia because of the potential for abuse, they like knowing if a patient is truly suffering, they do not have to worry even if they know the level of medication ordered will almost certainly result in the patient's death.

The same report of the House of Lords quoted above also addressed this problem saying:

> *Some witnesses suggested that the double-effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia and suggested that this implied medical hypocrisy. We reject that charge, while acknowledging that the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect. If this intention is the relief of severe pain or distress, and the treatment given is appropriate to that end, then the possible double effect should be no obstacle to such treatment being given. Some may suggest that intention is not readily ascertainable. But juries are asked every day to assess intention in all sorts of cases and could do so in respect of double effect if in a particular instance there was any reason to suspect that the doctor's primary intention was to kill the patient rather than to relieve pain and suffering. They would no doubt consider the actions of the doctor, how they compared with usual medical practice directed towards the relief of pain and distress, and all the circumstances of the case. We have confidence in the ability of the medical profession to discern when the administration of drugs has been inappropriate or excessive.*

(Source: Alan D. Lieberson, *Treatment of Pain and Suffering in the Terminally Ill*)

APPENDIX B – THE PRINCIPLE OF DOUBLE EFFECT

This principle aims to provide specific guidelines for determining when it is morally permissible to perform an action in pursuit of a good end in full knowledge that the action will also bring about bad results. The principle has its historical roots in the medieval natural law tradition, especially in the thought of Thomas Aquinas (1225?-1274), and has been refined both in its general formulation and in its application by generations of Catholic moral theologians. Although there has been significant disagreement about the precise formulation of this principle, it generally states that, in cases where a contemplated action has both good effects and bad effects, the action is permissible only if it is not wrong in itself and if it does not require that one directly intend the evil result. It has many obvious applications to morally complex cases in which one cannot achieve a particular desired good result without also bringing about some clear evil. The principle of double effect, once largely confined to discussions by Catholic moral theologians, in recent years has figured prominently in the discussion of both ethical theory and applied ethics by a broad range of contemporary philosophers.

Formulation of the Principle. Classical formulations of the principle of double effect require that four conditions be met if the action in question is to be morally permissible: first, that the action contemplated be in itself either morally good or morally indifferent; second, that the bad result not be directly intended; third, that the good result not be a direct causal result of the bad result; and fourth, that the good result be "proportionate to" the bad result. Supporters of the principle argue that, in situations of "double effect" where all these conditions are met, the action under consideration is morally permissible despite the bad result.

Each of these conditions has, however, been a matter of considerable controversy. The first condition requires some criterion independent of an evaluation of consequences for determining the moral character of the proposed action. Moral philosophers who believe that the moral character of an action is exhaustively determined by the nature of its consequences will, of course, object to this requirement.

The second condition assumes that a sharp distinction can be drawn between directly intending a result and merely foreseeing it. This requirement has been the subject of much debate. Some philosophers argue that if an agent recognizes that a certain consequence will inevitably follow from a contemplated action, then in performing the action the agent must be intending the consequence. Others argue, less strongly, that defenders of double effect have failed to delineate a practicable criterion for marking off the intended from the merely foreseen. Defenders of the principle typically respond by pointing to the implicit recognition of the moral significance of this distinction in the moral practices of ordinary persons.

The third condition writes into the principle of double effect the so-called Pauline principle, "One should never do evil so that good may come." Again,

philosophers who reject the view that actions can have a moral character independent of their consequences will find this condition unacceptable.

The fourth condition, by bringing in the notion of proportionality, has seemed to many philosophers to undercut the absolutism presupposed by the first condition. Although the first three conditions have a decidedly anti-consequentialist character, the fourth may appear to embrace consequentialist reasoning. Defenders of the principle typically attempt to accommodate the consequentialist character of the fourth condition while ensuring that it does not render the more complex features of the principle irrelevant.

Applications. The principle of double effect has played a significant role in the discussion of many difficult normative questions. Its most prominent applications are in medical ethics, where it figures prominently in attempts to distinguish among permissible and impermissible procedures in a range of obstetrical cases. The Catholic magisterium has argued that the principle allows one to distinguish morally among cases where a pregnancy may need to be ended in order to preserve the life of the mother. The principle is alleged to allow the removal of a life-threatening cancerous uterus, even though this procedure will bring the death of a fetus, on the grounds that in this case the death of the fetus is not "directly" intended. The principle disallows cases, however, in which a craniotomy (the crushing of the fetus's skull) is required to preserve a pregnant woman's life, on the grounds that here a genuine evil, the death of the fetus, is "directly" intended. There is significant disagreement, even among those philosophers who accept the principle, about the cogency of this application. Some philosophers and theologians, by emphasizing the fourth, "proportionality," condition, argue that the greater value attaching to the pregnant woman's life makes even craniotomy morally acceptable. Others fail to see a morally significant difference between the merely "foreseen" death of the fetus in the cancerous uterus case and the "directly" intended death in the craniotomy case.

(Source: Wm. David Solomon, "Double Effect," *The Encyclopedia of Ethics*) Lawrence C. Becker, editor

APPENDIX C – NEWSPAPER ARTICLES

Title **Belgium adopts law on mercy killing**

Source **The Courier-Mail**

Date Issue **25 September 2002**

Page **18**

Brussels: A controversial law decriminalising mercy killings came into force in Belgium yesterday, but patients seeking the right to die will have to wait a little longer because the paperwork is not ready.

Parliament passed the law in May despite opposition from the influential Catholic Church, making Belgium the second country after the Netherlands to allow euthanasia.

"The law became effective today but it's not yet applicable," a Health Ministry spokeswoman said, adding it would take a few days to finalise the forms that doctors practising euthanasia are required to complete.

Patients wishing to end their lives must be conscious when the application is made and repeat their request for euthanasia.

Their doctor must fill in a form and consult another physician before making a final decision.

Every mercy killing case would be filed at a national commission, which would decide if the doctors in charge had obeyed regulations.

"This law is very important because euthanasia exists and has been practised in secret," said Jacqueline Herremans, president of the Right to Die in Dignity Association.

Title **A time for dying (euthanasia debate)**

Author **Paul Syvret**

Source **Bulletin with Newsweek**

Date Issue **24 September 2002**

Page **24**

It is the debate that few want to have, but despite the misgivings, writes Paul Syvret, we may be moving towards a de facto acceptance of euthanasia.

Pamela Watson describes herself as "a bleeding heart and not ashamed of it".

An anthropologist, she has spent many years researching the use of medicines by tribal groups, and more recently examples of genocide in settler societies such as colonial Australia.

The 75-year-old is spry, witty and passionate about issues of social justice and equity.

Sitting at an occasional table in her unit overlooking the Brisbane River, she talks enthusiastically about a chapter she has contributed to a book to be published in New York next month.

But one day, hopefully not for many years, she may take her own life. Kill herself.

Watson is not dying, she's not sick, and certainly seems far removed from being depressed.

She simply wants the choice.

If and when the time comes, Watson knows how she'll do it.

She'll go to a cupboard and remove a plastic bag - a large innocuous-looking bag with a drawstring.

Innocuous, that is, except for a warning label stating: "This bag may kill you". She'll place the bag over her head, draw the string firmly around her neck, lie back and slowly die of asphyxiation - lack of oxygen as opposed to choking or suffocation.

Macabre?

Maybe, but more dignified and peaceful than many other methods of suicide.

And, as proponents of voluntary euthanasia argue, more dignified and peaceful than a painful, protracted and ultimately helpless departure at the hands of an evil such as cancer.

The Greek origin of euthanasia means "easy death".

Last month, Watson became an unwitting poster lady for voluntary euthanasia when euthanasia evangelist Dr Philip Nitschke paraded her before a media scrum at the launch of his plastic "exit bags" in Brisbane.

Unwitting at the time, perhaps, but not unwilling.

Death, she says, "isn't very pretty in any circumstances ... but then, nor is a face ravaged by cancer".

Watson hopes she will never have to use her exit bag or, for that matter, make the decision to hasten her leaving.

She was very ill two years ago and says that it was the first time in her life she had been totally helpless.

"It made me realise that people who are seriously ill are so vulnerable.

If your doctor is of a certain set, you basically can't make your own choices about the course and treatment of your condition.

I also learnt that morphine doesn't really take the pain away at all - it just distances you from everything".

Watson and the broad church that is the voluntary euthanasia movement in Australia want legalised access to drugs such as Nembutal (a powerful barbituate) and the right to seek assistance in ending their suffering if they are terminally ill.

Exit bags are far from ideal, but at least under current law they are not illegal.

And as euthanasia campaigners point out, if you are going to start banning plastic bags because they could be used as an instrument of death, we may as well dispense with kitchen knives, razor blades, rope and tall buildings.

Indeed, much of Watson's spleen is vented towards federal Minister for Ageing Kevin Andrews, whose bill a few years ago killed the Northern Territory's (and world's) first voluntary euthanasia legislation, introduced by then chief minister Marshall Perron in 1995.

"Kevin Andrews has condemned tens of thousands of people to unimaginable pain and suffering," she says.

"I'm happy for them [Andrews and supporters] to suffer if they feel they have to suffer for their god but don't force that on me".

Or, as Nitschke, puts it: "What our politicians are saying is, 'OK, you've got the right to die, but by hell we're going to make it as miserable as possible'."

Nitschke, over a few beers after the Voluntary Euthanasia Society of Queensland's annual meeting, looks tired.

His mobile phone rings incessantly, its battery almost dead - lawyers, supporters, the media, always the media, wanting a piece of him.

He's staying at a supporter's home, resting for a day, then driving to Sydney - his brand of activism doesn't pay well.

And the Nancy Crick business and its ensuing legal mess has stretched finances exceedingly thin.

In May, Crick took her own life with a lethal overdose in the presence of 21 friends and supporters.

The world discovered only after her death that she was no longer suffering from the cancer which had seen most of her bowel removed.

For Nitschke and his supporters, it was a strategic and public relations disaster.

Here was a woman, obviously suffering and apparently riven by cancer who in actual fact didn't have cancer at the time of her death.

When it was revealed that Crick's body was no longer being eaten away by cancer, pro-life organisations - or anti-choice groups, if you like - seized on the revelation with gusto.

It was, they said, proof positive that interfering with the natural course of life (and death) is an unforgivable crime.

As Queensland police continue to investigate the circumstances of her passing, Nitschke remains unrepentant: "It is an academic point as to whether she had cancer or was suffering the effects of cancer and that cancer's treatment.

She was a suffering individual.

Nitschke points out that under existing Queensland law, the crime of advising, counselling or assisting a suicide carries a maximum penalty of life imprisonment.

The Crick case he describes as an example of "mass civil disobedience". Crick, of course, procured her own drugs.

Her death, her business.

Albeit with friends.

The issue tends to so polarise people, however, that few in the political arena have the courage to tackle it.

Defending the status quo is deemed far preferable to attracting the public condemnation of religious groups.

Aside from Queensland Premier Peter Beattie vowing to hold the line in terms of existing legislation, but in the same breath saying quite sensibly that we can't ban plastic bags, little is heard post-Andrews and Perron.

Little, that is, except for independent MP Peter Wellington, who has introduced the Care of Terminally Ill Patients Bill into the Queensland parliament.

Both sides of the debate have attempted to hijack this piece of proposed legislation for their own ends.

Some anti-choice groups - including the broader Catholic Church which, in the Catholic Leader, described it as anti-euthanasia - have decided it is a fair compromise.

On the other side of the equation the likes of Nitschke say that Wellington's proposals, "take our opponents to the very edge of what they are prepared to have".

In short, Wellington proposes legislation that will absolve doctors whom, when treating a terminally ill patient, administer quantities of pain-relieving drugs that may as a side-effect also hasten the death of the patient.

According to Wellington, "many Queensland doctors hold back from prescribing enough medication to effectively relieve pain in the terminally ill because under present state law they could be prosecuted if their patient dies as a consequence".

It is about erasing "grey areas", he says.

At present, Wellington is negotiating the passage of the bill with Queensland Attorney-General Rod Welford.

Given the tacit support of groups such as Queensland Right to Life, it appears the law will be changed.

According to QRTL, it "does not object to the withdrawal of burdensome treatment or the administration of pain-relieving treatments intending specifically to control pain, that may - as a secondary effect - bring forward the time of death".

Also consider a report by Monash University researchers who found after surveying (confidentially) some 3000 doctors that nearly a third of deaths in Australia occur after doctors decide to intentionally hasten them.

In fact, according to the university, the incidence of doctors administering life-shortening drugs without first discussing the action with patients (non-voluntary euthanasia) is five times higher than in the Netherlands, where euthanasia is legal.

The director of Monash's Centre for Human Bioethics, Associate Professor Helga Kuhse, says that "it does make sense that researchers concluded that doctors working in a country which prohibits euthanasia or intentional termination of life by act or omission would be reluctant to discuss end-of-life decisions with their patients".

Further, she argues that, "our findings undermine suggestions that allowing euthanasia to be practised openly makes it more likely that doctors will end patients' lives without their consent".

Nitschke says the euthanasia issue is similar to that of abortion 25 years ago.

"You had access to the procedure if you had the right connections and if you had the money - it became a class issue".

While anti-choice groups tend to be more vocal, polling indicates that the vast majority of Australians support the legalisation of voluntary euthanasia - subject to strict control - for the terminally ill.

Polling by Roy Morgan Research in June found that more than 70% believed the law should be changed to allow for voluntary euthanasia.

Conversely, just 23% said they thought there was sufficient palliative care available for the terminally ill.

Indeed, in his final year of medicine at the University of Sydney in 1988, Nitschke recalls that there was just one lecture on palliative care.

Anti-euthanasia campaigners, such as Cairns GP Tim Coyle, agree that considerably more money should go towards palliative care, in particular, funding for hospices.

Coyle, a practising Catholic says it is not just his faith that underpins his objection to euthanasia, but "a professional distaste to acts of deliberate killing".

He and the QRTL are not actively lobbying on the issue at present, believing that Nitschke and his supporters will come unstuck at the hands of the law.

"With the exit bags, for example, as far as I am concerned what he is doing is illegal.

I certainly believe it is only a matter of time before he comes before the courts."

Coyle quotes at length from a British House of Lords committee finding on euthanasia:

"Belief in the special worth of human life is at the heart of civilised society...

Society's prohibition of intentional killing is the cornerstone of law and social relationships.

It protects each one of us impartially, embodying the belief that all are equal.

We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia ...".

Like other pro-life campaigners, Coyle is appalled by the Crick case.

Rather than being terminally ill, "she was depressed and unwell", he argues.

But as a hale and hearty Watson put it: "If you were dying, of course you'd be depressed.

Depression is not a pathological thing, it is very natural.

So is death…".

Title **Bill to aid terminally ill patients**

Source **The Courier-Mail**

Date Issue **19 June 2002**

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A new Bill treading the fine line between easing the suffering of the terminally ill and voluntary euthanasia will be introduced to State Parliament today.

Independent Member for Nicklin Peter Wellington said his Bill, based on successful South Australian legislation, had the support of the Queensland branch of the Australian Medical Association and the Catholic Archdioceses of Brisbane.

He said his Bill would ease pain as well as change Queensland law to protect doctors.

"At present doctors who prescribe enough medication to relieve pain and suffering, and in doing so inadvertent[ly] shorten a patient's life, can be sued," he said.

"My Bill will protect these doctors from litigation providing their primary aim in administering medication is to relieve pain even though a secondary effect may be the shortening of life."

APPENDIX D

POPULATION AND RECURRENT FUNDING STATISTICS FOR PALLIATIVE CARE SERVICES IN QUEENSLAND HEALTH DISTRICTS[55]

Southern Zone

	Population	Annual Funding	Per Capita
Charleville health district	8 860	$ 47 000	$5.30
Gold Coast health district	330 361	$617 619	$1.87
Logan/Beaudesert health district	251 702	$277 687	$1.04
Northern Downs health district	29 847	$ 79 000	$2.65
Princess Alexandra and Mater Hospitals health district	389 244	$454 720	$1.16
Queen Elizabeth II Hospital and Bayside health district	554 303	Not available	Not available
Roma health district	17 059	$ 72 000	$4.22
Southern Downs health district	54 518	$ 71 000	$1.41
Toowoomba health district	131 630	$305 000	$2.32
West Moreton health district	171 590	$336 000	$1.96

Central Zone

Banana health district	13 728	Unknown	Unknown
Gladstone health district	41 468	$ 90 450	$2.18
Bundaberg health district	81 734	$130 675	$1.59
Central highlands health district	24 298	$ 22 300	$0.92
Central West health district	13 362	$ 2 030	$0.60
Fraser Coast health district	73 850	$ 50 750	$0.68
Gympie and Sunshine Coast health district	257 696	$259 625	$1.00

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[55] Elizabeth Adams and Yolanda Schweizer, *Palliative Care in Queensland: The State Defined*, March 2001.

North and South Burnett health district	42 149	$ 55 750	$1.32
Redcliffe/Caboolture health district	160 512	$272 250	$1.70
Rockhampton health district	98 448	$145 058	$1.47
Prince Charles, Brisbane and Royal Womens, and the Royal Childrens Hospitals health district	509 117	$873 836	$1.71
Northern zone			
Bowen, Charters Towers and Townsville health districts	198 162	$563 900	$2.84
Cairns health district	133 954	$614 311	$4.58
Cape York health district	7 651	$ 41 049	$0.96
Innisfail health district	33 180	$ 62 490	$1.88
Torres health district	9 018	$ 41 574	$4.61
Mackay health district	104 976	$435 100	$4.15
Moranbah health district	20 853	$ 19 962	$0.96
Mount Isa health district	31 088	$162 350	$5.22
Tablelands health district	36 992	$ 66 876	$1.80

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