

Crime or care? The problem of cause of death and intention to kill, in end-of-life care

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Introduction

In this talk I shall briefly discuss the nature of palliative care and the concepts of causation, intention and the doctrine of double effect in the context of the care of people at the end of their lives.

What is palliative care ?

The World Health Organization defines palliative care as “an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

There are several things to note about this definition.

1. There is no mention of the word “cancer”. The definition refers to all life-threatening illnesses. A significant proportion of the work of palliative care involves patients with serious heart, lung and kidney diseases and neurological diseases such as Motor Neurone Disease and advanced dementia.
2. The definition refers to “early identification”, not waiting until the patient is dying. One of the myths about palliative care is that it is simply terminal care. A palliative approach, based on the needs of the patient and their family, rather than the extent of the disease, may be adopted at any point in the course of the illness.
3. Finally, the remarkable adverb “impeccable”. The standards set are very high.

That is the official definition.

Unofficial definition

Perhaps the best unofficial definition of this discipline is contained in a poem, not written by a patient or carer who experienced palliative care, but by one who regretted that he did not. The poet is Bruce Dawe. The poem is :

[White Water Rafting and Palliative Care](#)

for my late wife, Gloria

If I had understood (when down the river
you and I went swirling in that boat)
that there were those who knew the ways of water
and how to use the oars to keep afloat
– I might have been less deafened by the worry,
less stunned by thoughts of what lay up ahead
(the rocks, the darkness threatening to capsize daily),
if I had only realised instead
that help was all around me for the asking
– I never asked, and therefore never knew
that such additional comfort could have helped me
in turn to be more help in comforting you.
I'd have found it easier then to simply hold you
instead of bobbing to and fro so much,

for it was *you* who seemed to be more tranquil
and *I* whom death was reaching out to touch.
If only I had had sufficient knowledge
in that white-water rafting I'd have learned
that there were those around us (with life jackets)
to whom I might have, in that turmoil, turned.
Instead, because I had not thought of rivers,
or rocks, or rapids, and gave way to fears
that seeking help might make a man less manly
and liable to betray himself with tears,
I was less useful then, as twilight deepened,
than I might well have been, had I but known:
however wild the waves that roll around us
– no one needs to live (*or die*) alone ...

This is wonderful language. It uses the powerful image of a cascading river to capture the experience of being diagnosed with a serious illness and the loss of all sense of control. Much of our work in palliative care is the use of 'oars' and 'life jackets', the restoration of comfort and the attempt to wrest some sense of control and equanimity for both the patient and their family.

Palliative care within the medical profession

What is the view of palliative care within the medical profession as a whole? Palliative care is a relatively new discipline. With greater exposure to the discipline, there has been a growing recognition of its role from within the wider medical community. However – and it is a significant however – palliative care physicians are still subject to comments such as: “Introducing you to this patient will send the wrong message to her... No, not now, she is not ready for it... I will refer her when I've exhausted all active management – but not before.” These statements reveal fundamental misconceptions of the role of palliative care. The first misconception is that palliative care is simply care of the dying. The second is that by introducing palliative care you are removing all hope.

In response to the first issue, significant skills in all aspects of symptom management and psychosocial support can be brought to a patient well before the dying phase. We are saddened when our first contact with a patient occurs when they are dying, especially when the period leading up to that point has been immersed in suffering that could have been addressed much earlier.

The second issue is hope. Hope is intrinsic to us as human beings. In a serious illness, like cancer, all hope may be invested in cure. One of the crucial aspects of palliative care is to preserve and foster hope. It may be evident that hope no longer lies with cure. Hope, the sense of the imagined future may now lie in other aspects of care – the hope that you will be treated to the best of our ability, that you will not needlessly suffer, that you will always be listened to, that you will be treated with respect at all times and that your death, when it does come, will be comfortable, dignified and loving. A further analysis on hope in this context appears in [Illness, Crisis and Loss](#).

Alleviating pain or euthanasia: the doctrine of double effect

The 'Doctrine of Double Effect' has its modern antecedence in the work of Thomas Aquinas in the 13th century. [The doctrine](#) provides that an action that had both good and bad effects may be morally justified if only the good effect is intended and the bad effect merely foreseen, provided that the action itself is morally permissible, that the bad effect is not a means to the good end and that the good effect achieved is great enough to outweigh the bad.

One perception of palliative care held by some doctors, lawyers and the lay public is that, in practice, the discipline is repeatedly and permanently reliant on the doctrine – walking a fine line between analgesia and precipitating death prematurely. Consider this recent statement by a psychiatrist discussing end-of-life care in [The Age](#) and *The Sydney Morning Herald*:

“...there is a spectrum of actions that hasten death...One that happens every day in hospitals, hospices and nursing homes is when medications like morphine are increased to alleviate debilitating pain, causing the patient to stop breathing and die.”

The sweep of this statement is deeply troubling. The lay public may view this statement by a medical specialist as authoritative. It could well create a perception that such practice is both routine and accepted medical practice.

Unfortunately, perceptions have taken hold and grown over the years. In 1996, Billings and Block wrote in the *Journal of Palliative Care* (12:21-30): “The use of a morphine infusion is ‘slow euthanasia’”. Last year, [a Sydney journalist describing the death of his father](#), concluded: “Increasing doses of morphine completed what was, by any reckoning, a type of passive euthanasia that happens in our hospitals and nursing homes every day.” [An academic describing the last days of her mother’s life with cancer wrote](#): “In the hospice, the morphine made the last few days bearable – and killed her. This is what ethicists call double effect...”

How have these views gained currency ? Do they represent reality ?

Opiophobia and opioignorance

Within the medical profession, what are the origin of these views? In simplistic terms, there are two issues – ‘opiophobia’ and ‘opioignorance’ – the fear of opioid use and a lack of training in the safe use of opioids. Generations of doctors have graduated with little or no training in pain management, palliative medicine or the care of the dying patient. The general community may be shocked by this, but it is true. Generations of doctors have graduated with no, or very limited, training in the safe use of opioids.

This paucity of training, combined with the ubiquitous fear of opioid use in the wider community has allowed myths to flood into this area of medicine. Myths abound. They include :

1. That opioids given for cancer pain are addictive. Addiction is disappearingly rare in this context.
2. That opioids inevitably cause sedation, confusion and suppress breathing. That is a myth. Many of our patients tolerate significant doses of opioids and function perfectly normally in the community without these side-effects. The key issue here is proportionality and tolerance. It is true that if excessive doses are given, the patient will become opioid-toxic and will experience side-effects. The clinical response is to lower the opioid dose or to introduce other analgesic medications.
3. That – as death approaches – standard care is to increase opioid doses independent of the pain of the patient. That is a myth. This impression has wide circulation, as evidenced by the quotes cited above. The issue here is pain, not proximity to death. The standard of care is to adjust analgesic dosing, including opioids, according to the level of the pain of the patient, not according to the extent of the disease or proximity to death.

Studies on medical practice

It is with that background that it is perhaps now interesting to look at some major studies of the practices and attitudes of doctors.

In 1997, a study was published in [The Medical Journal of Australia](#). It looked at end-of-life decisions in Australian medical practice. Its conclusion was that, of the deaths in Australia that involved an end of life decision, 30.9 % involved the use of opioids under the principle of double effect. In 2001, [a survey of Australian surgeons was published](#). Of the respondents, 36 % reported that, for the purpose of relieving the patient’s suffering, they had given drugs in doses they had perceived to be greater than those required to relieve symptoms, with the intention of hastening death.

Nexus between treatment and death?

Reading these studies (and other doctors’ reports of giving opioids and sedative medications to hasten the death of a patient) provokes scepticism. Was there truly a causal nexus between the action of a doctor and the death of a patient ? This question is particularly relevant given that generations of

doctors have not been adequately trained in this area. In terms of causation and medical practice, there are issues here – of proportionality, timing and tolerance – which need to be considered.

Proportionality

In the context of analgesia, the doctrine of proportionality states that opioids should be given proportionate to the level of pain. The same would be said about medications for agitation at the end of life. Indeed, this is a principle that applies across medicine – that treatment is always given in proportion to the symptom.

In the absence of case data in the above studies of doctors, it is impossible to know whether the doses given were truly disproportionate to the symptoms being treated. Indeed, in the absence of training in the use of these medications, there may be a significant divergence in what the individual thought was excessive and what truly was so.

In the context of palliative care, in all the studies ([Bercovitch et al](#), [Morita et al](#) and [Thorns and Sykes](#)) on the effect of opioid use on survival, none have shown that opioids shorten life. These studies show that there were no differences in survival between patients receiving high doses and low doses of opioids where that dosing was in proportion to the level of pain.

Timing

Timing is another issue. These drugs are frequently given close to the time of death. Consider, for example, the case of an 83-year-old man with metastatic prostate cancer. He is very ill. He has been deteriorated steadily over the past two weeks. He is now unconscious and dying. The family has gathered. He is getting a steady infusion of morphine that is the identical dose that he was on when he was awake and could swallow tablets. If he has signs of pain by grimacing or groaning, he is given an extra dose of morphine in proportion to the overall doses he has been receiving. He groans. The nurse gives him an extra dose. He dies five minutes later. A relative says “You’ve killed him. I saw you gave that extra dose of morphine and then he died.”

This does happen. The palliative care physician sits with the relatives and says “No, he died because of disease. He was dying because it was his time. His disease had brought him to his death, not the use of these medicines.” If families continue to query it, the palliative care physician will sit down with them and go through the figures: “Look at the dose he was on four or five days ago when he was swallowing. He was on an identical dose now. Look at the dose he was given. This is in proportion to the level of his pain. He has not died of the opioid.”

Tolerance

Another issue is tolerance. Over time, with dosing, a person develops a tolerance to the respiratory effects of opioids. [Fohr](#) concluded that when opioids are used appropriately for pain relief, the risk of respiratory depression is more myth than fact. Nevertheless, the myth persists.

Causation

When a statement or implication is made that palliative care is repeatedly and permanently relying on the double effect doctrine – even prior to any discussion of intention – there is the issue of causation. There are other issues in causation, but proportionality, timing and tolerance are crucial in terms of looking at this, because if one assumes that the giving of the medicine led to the death (without even questioning this assumption) then nuances in terms of medication and care are missed. As [Ashby](#) states: “Opioids and sedatives drugs can be used quite safely for symptom control without bringing causation into question if the parameters of accepted practice are followed.”

These are very basic principles. In the light of this discussion consider once again [the earlier quotation](#): “...there is a spectrum of actions that hasten death... One that happens every day in hospitals, hospices and nursing homes is when medications like morphine are increased to alleviate debilitating pain, causing the patient to stop breathing and die.”

This comment is concerning. Several hundred thousand Sydney residents reading the newspaper, noting that the author was a doctor, may think: “Oh, my God! What is going to happen to us when my parents or I get to hospital with a serious illness ?”

One needs to be very careful here and answer this question: does the practice of rapidly escalating doses of opioids – irrespective of symptoms – occur? Yes, it does; we cannot pretend it does not. The difficulty with the above quotation is that it may give the impression that such practice described is both routine and standard, accepted medical practice. It is neither. And so, prior to any legal commentary on this practice, self-reflection needs to occur within the discipline of medicine. It is poor medicine to be escalating opioid doses regardless of the level of symptoms. It ignores decades of research, advances in knowledge of the safe use of these medications and clinical expertise. Poor medicine compounds an already complex picture.

Arguably, for doctors, at a deeper level, it may reveal an ambivalence about death itself. Professor Brian Kelly's [statement](#) provides a helpful insight:

“To what extent is the issue of assisted suicide or euthanasia symptomatic of the failure to equip doctors with better skills in the care of the dying?... The reactions of doctors tell us less about the appropriateness of euthanasia... than they do about how troubled and problematic the medical responses to a dying patient can be a ‘symptom’ of the problem modern medicine has with dying rather than the solution.”

Progress in palliative care training and awareness

While generations of doctors have been inadequately trained in pain medicine and palliative care, the modern era has witnessed a quiet revolution in the training of medical students. In many, although not all, medical schools, there is more time and teaching devoted to these issues. It is an indictment of the profession of medicine that these issues have not been adequately dealt with in education and training.

Doctors' intentions

Consider now intention. I have set out the definition of the doctrine above. Intention is crucial to the doctrine's application.

The difficulty with the doctrine of double effect in the context of doctors and their actions at the end of life is that one enters a hall of mirrors. Discerning the intention of a doctor may or may not be difficult, according to the circumstances :

1. It may be abundantly clear, clearly thought out and clearly expressed that the doctor intends to cease the patient's life.
2. Another category is the doctor who intends to cease suffering by giving medications, where he or she is conscious that by doing so death may ensue as a result of his or her actions. That is the classic double effect situation.
3. The third category exists where the doctor's intention is ill-defined, a mixture of clinical judgement and emotions, inchoate and difficult for the doctor themselves to discern clearly. As [Douglas](#) stated in 2010, “[Some doctors] don't have a lot of good understanding about the dying process... we find that [the doctors] who are less experienced with the management of dying are the ones more likely to be ambiguous, and more likely to think, “Well, you know, it's not right, it's not really clear whether I'm killing this patient or just keeping him comfortable.”
4. There is a fourth category. That is where medications are given purely for the relief of symptoms, where doses are proportional to the level of those symptoms, where signs of excessive dosing are carefully monitored and where there is absolutely no intention to cause death.

Foreseeability and the law- splitting Intention and Foreseeability

It is the middle two categories where the doctrine of double effect applies. Immediately, however, one comes up against a fundamental principle of criminal law. Generally in the criminal law, if it is foreseen that an action will cause death, then the *mens rea* has been found. In the doctrine of double effect, intention and foreseeability are split. Professor Cameron Stewart, who shared the podium on the evening of this presentation, has [written and spoken about this eloquently](#).

No Reasonable Alternative

Arguably there is a further aspect of the doctrine : that there was no reasonable alternative to one's actions. Writers such as [Sulmasy](#) and [Cavanaugh](#) argue that the doctrine of double effect should only apply to the toughest cases where there was no reasonable alternative but to cause harm in trying to fulfil one's duty to bring about some good.

Following this argument, the final part of the doctrine of double effect in this context provides that there must be no other reasonable way of achieving pain relief or sedation or dealing with the psychological anguish of a patient without involving the undesired effect of shortening life. For a doctor justifying his or her actions on the basis of the doctrine, one would ask several simple questions: "Did you consider if there was an alternative here ? Specifically, did you seek the advice or assessment of palliative care?"

Conclusion

This is a very complex area. It does not lend itself to easy simplification. The issue of opioid use and sedation at the end of life has both medical and legal implications. In terms of the law, there are issues in both causation and *mens rea* (intention). From a medical perspective, causation is complex in the setting of end of life care. Issues of proportionality, timing and tolerance, amongst others, arise. Causation is usually not an issue in palliative care where universally recognised guidelines of management apply and where doses of medications are used proportionately and carefully. However, intention can be, according to the individual circumstances, either plain or difficult to discern. There are problems with the doctrine of double effect and if it is applied, one must be conscious of the issue of possible alternative actions.

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