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

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## Introduction

People tend to forget why we have law. It is not discussed enough. It is simply presumed that it is needed. One could sometimes think that society would be better without it.

This paper surveys the basic criminal law notions of 'intention' and 'causation' in homicide. It compares those approaches generally with their application in life settings, including palliative care, but also in the management of withdrawal of treatment – what is now being referred to as 'death management' – and highlights the need for further reform.

## Current status of the law relating to end-of-life care

The law relevant to end-of-life care is in a disgusting shape. Our parliaments have completely failed to fix it. It is something everyone needs to be terribly concerned about, because everyone is going to die. This is one of those rare areas of law where every person has a personal stake in making sure that it is the best possible law that a society can have. At the moment, our society does not have it.

At the moment, judges, at the least in the Common Law Division, have tended to distort rules – in good faith – to attempt to allow particular types of death acceleration in particular groups of patients. While this is well-intentioned, these distortions have done wide-ranging damage to the structural integrity of the law. The contradictions cause confusion and ultimately bad health-care or they lead to bad health-care outcomes.

## The need for change

'Therapeutic law' needs reform. The law needs to be fixed. The law has a responsibility. Therapeutic jurisprudence is an important concept as the law forms an aspect of health care and needs to play a role in that. The reform can come from statute. The easiest solution would be to fix up the laws, particularly in the guardianship area. If that is not possible, then it will be up to the judges to make the reforms.

Not all intensive care withdrawal involves 'killing', but one must recognise that death is managed in new ways in modern times. That needs to be reflected in our understanding of the legal mechanisms by which that can occur.

Similarly, not all palliative care involves 'killing'. In fact, it might actually extend life. But, again, there might be situations – particularly with the misuse or mismanagement of opiates and sedatives – which might lead to death.

**The debate**

This paper's conclusions are not designed to lead to an acceptance of the need for assisted suicide schemes, but they might change the nature of the debate. There does not necessarily need to be a 'physician-assisted suicide' law, but current practice does need to be fixed. If that is done, then there might be a better chance of debating that issue sensibly.

**Why do we have a legal system?**

We have a legal system in the hope of the ethical function of the rule of law. It is never quite achieved, but that is what should always be aimed for.

**The rule of law**

The rule of law requires all of the following:

1. laws that are certain, that operate with certainty;
2. laws that operate in forms of generality, so that they work across populations; and
3. laws that are concerned with equality, in that like cases are treated alike and different cases are treated differently. The conversation must be had about what is just for the treatment of difference and sameness.

**The function of law**

Law is important not only as a mere means of resolving disputes. Law is important to lay down the framework for action in our society. If law is unclear, people will not know how to act. Law always tends to be thought of as what happens when something goes wrong. It is not. It is there all the time in what one does on a day-to-day basis.

Health care practitioners rarely appreciate that the law is there all the time, influencing their actions. They often think that the legal system is solely a monster which will come and grab them when they make a mistake. The dispute resolution system is an important part of law, but it is not the most important. In fact, it is a system failure in one sense. If law were clear, then most people would know what to do and they would not get into trouble in the first place.

**Basic Criminal Law**

Crimes have elements of intention and causation, and potential defences.

***Intention***

There are two levels of intention: actual intention and recklessness. There are concerns about the concepts of recklessness. Since the case of Crabbe, if one acts knowing that the probable consequence of that action is death, it means, for the purpose of criminal law in Australia, that one has an intention to kill.

***Causation***

There are many tests of causation including the 'reasonable foreseeability test', the 'substantial cause test' and the 'natural consequence test'. All these causation tests tend to reflect the common-sense idea of justification.

Causation is not only factual, but it is also normative in the sense that we look at whether one ought to be found to have caused a particular outcome.

Omissions are generally not found to 'cause' death unless a person has a duty to act. It is in the context of the discussion on duties, particularly in attended care settings, that issues arise about whether one has caused death or not.

***Defences***

Some defences are complete (such as self-defence, defence of others or insanity); some are partial (like suicide pacts or provocation).

One of the problems is that consent is not a defence. It is not raised as a defence, except in situations where the consent was to a grievous bodily harm and there was a public justification in that activity, such as boxing and playing rugby league. If one accidentally hurts someone or kills them in the context of playing rugby league, it is not a criminal issue because the person had consented to playing and there is supposedly a public interest in rugby league.

**Refusal of treatment**

In the context of medical care, there was previously a need to rely on British and American cases, but now it is clear in the Australian context that a person can refuse treatment even if that means they are going to die in a painful and ugly way. This was recognised last year by the Supreme Court of Western Australia in the case of Brightwater Care Group Limited v Rossiter. Mr Rossiter, a quadriplegic, decided that he did not want to live anymore; so he refused artificial feeding, as well as antibiotic treatment should he need it. He died from an infection, brought on by the lack of food. He could have been treated with antibiotics.

Probably more disturbing is another case involving a woman in South Australia who did a similar thing at the end of last year. She was partially paralysed from post-polio syndrome. She refused insulin for her diabetes and also refused food. At hearing, (H Ltd v J) the judge said that this was not suicide because she was refusing treatment, not acting. There is a problem with looking at this and saying that it is not suicide. I consider it suicide. Suicide is certainly not a crime. Some suicides we respect and some we might not, but we should not twist the law to get a result that we like. The discomfort at the legal level needs to be dealt with.

**Suicide**

I believe that both cases of Rossiter and J involve deliberate intentional choices to die. Suicide can occur by omission. If one stands in front of a train, it is the omission to leap out of the way which causes death. A debate must be had about suicide support because it is a chronic problem in society. Suicide is not talked about enough. It needs to be talked about more.

In terms of legal responsibility, there is no right to get assistance for suicide. Certainly one has a right to act alone. It is the drift from the negative right to the positive right that needs to be focused on.

**Assisted Suicide**

Assisted suicide is full of problems. Judges prefer to call these actions 'non-suicidal' because they do not want the doctors to be held criminally responsible for providing comfort and care while the person is starving themselves to death. Assisted suicide is criminal. High levels of assistance (such as injecting or providing drugs to cause death) might even be homicide (R v Justins [2008] NSWSC).

**Management of withdrawal of treatment**

The management of withdrawal of treatment is different from the deliberate intentional choice of the patient to refuse treatment. There are situations where patients cannot make decisions for themselves. Indeed, with these patients, the treatment is no longer providing any form of benefit.

**Bland's case**

This was primarily talked about in Bland's case, a British case involving the withdrawal of treatment. It is still one of the few cases which deliberately and directly looks at the issues of intention and causation. There are Australian cases which talk about withdrawal of treatment, but not about the intention and causation aspects.

A 19-year-old man had been injured in the Hillsborough disaster. After being without oxygen for 20 minutes, his brain had been destroyed. He still had a functioning brain stem, so was technically still alive. The family, the doctors and the Catholic priest who was giving advice at the time all believed that, in the best interests of this patient, they should withdraw feeding through a tube in his stomach.

The House of Lords looked at this because the doctors asked for protection. The House of Lords asked, "Was there an intention to kill?" And they said, "Yes, there is." It is not the motive that they are interested in, but the intention. "Do you know that what you are doing is going to cause this man's death?" "Yes, we do know it." So there is an intention to kill. What about causation? Did the doctors cause the death? The answer the House of Lords gave was: "No, they did not cause the death." How do we get there?

They say it is an omission to withdraw treatment and that one is liable for omissions only when one has a duty to act. There is no duty to act here because treatment is not in Anthony's best interests. Interestingly, 'best interests' in that case was defined by the Bolam test – what a responsible body of

medical opinion would believe were the best interests. As Australians, we need not worry about that, because we do not necessarily follow Bolam. Since then, there have been other UK cases which have followed the same approach. Therefore, the best interests test is wider than a purely medical decision, even in Britain.

**Problem: withdrawal of treatment involves action**

The problem with Bland is that while withholding treatment is an omission (because one is not doing anything), the actual withdrawal of treatment involves a level of activity. If one thinks about people on ventilatory support, machines need to be turned off, feeding tubes need to be removed, etc, and there are also drugs, such as paralysing agents, which need to be ceased.

The problem is that, with all of those activities, the removal has to be classed under an umbrella of 'not doing'. If one swaps the individual who is doing the withdrawing, so instead of a doctor doing these things, it is just an interloper who walks in off the street and started pulling the tubes out, it would be said that that was murder, that it was an action; but when a doctor does it, in a particular context, it is an omission. Now the fallacy can be seen.

The fallacy is that our understanding of the activity is changing purely because we want to manufacture a particular outcome. It actually has nothing to do with the activity as such, but with who is doing it, but that is not what the law says. The House of Lords is deliberately manipulating the law, the established law of acts and omissions to get a result that it wants. This manipulation, if adopted, might damage the law and result in some perverse outcomes.

**Terminal palliation**

Terminal palliation is the practice of rendering a person partially or totally unconscious to relieve pain even though a secondary effect is to shorten their life. However, it should not be presumed that all opioid or barbiturate treatment causes death. Their proper management and use might actually extend life. Nevertheless, the common law legal systems around the world have all said that if one were to perform this action knowing that one was accelerating death, then that is acceptable, as long as the primary intention is to relieve pain and not to cause death.

Adams was one of the first notorious serial killers (R v Adams). He tended to kill old ladies. He was acquitted by the jury after the Court gave the jury this instruction about the double effect: that "if the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life".

Cox was a doctor who was treating a friend. He ended up giving her a big dose of potassium chloride to kill her. He argued that she was in untreatable pain, but he could not argue double-effect because there was none. Therefore he was convicted of attempting to murder. The Court stated, "There can be doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death". [R v Cox (1992) 12 BMLR 38]

In Pretty, which is a case about the right to assistance, in *obiter* the House of Lords discussed that people could administer analgesics which would hasten death, as long as the outcome is foreseen but not intended.

Terminal palliation has also been recognised in Canadian (Rodriguez v. British Columbia (Attorney General) [1993] 3 S.C.R. 5190; R. v. Morrison, 1998 CanLII 2075 (NS S.C.); re Taschuk Fatality Enquiry, 1983) and US cases. The two United States cases on the topic (Vacco v. Quill, 117 S. Ct. 2293 (U.S. 1997); State v. Naramore, 965 P. 2d 211 - Kan: Court of Appeals 1998) were in the context of physician-assisted suicide. The United States Supreme Court recognised that there might, in fact, be a human right to pain relief which allows for acceleration in particular circumstances.

**Manipulating the Law**

What is the problem then? If everyone says that we can do it, why do we worry about it? The problem in our system is that – in all other circumstances – if one can foresee death, then one has an intention to kill. In Australia, knowledge of the probability of death is an intention to kill. The fact that someone is a doctor and has the motive of treating pain is irrelevant to the question of whether or not he has an intention to kill. Under the ordinary laws, that is what would be said. Mustill J in Bland stated that the fact that the doctor's motives are kindly makes no different in law.

The other principle is the acceleration principle. In other circumstances, one cannot kill people and then say it is acceptable as they were going to die anyway. Yet this is what was said in Cox and also in Adams. The problem is that traditional principles are being distorted: in some cases doctors are being prosecuted for activity which should be encouraged, and in some cases doctors who are excused for behaviour which should be questioned and examined.

**Two examples**

One example comes from Dr Naramore from Kansas. Dr Naramore used palliative care on a patient while she was terminally ill from cancer. There was a dose given. She died soon after. The family said "You've killed Mum". He was convicted of first degree murder. The case went all the way up to the Supreme Court of Kansas and the Supreme Court of Kansas held that no reasonable jury could have come to that conclusion. They did not explain why. They simply quashed the conviction and let him go.

Dr Naramore was also convicted of second degree murder for another case where he withdrew treatment from someone. The Supreme Court of Kansas also overturned that conviction. This doctor, who was doing the right thing, was convicted (although it was overturned). Other doctors have been convicted after properly treating patients.

Conversely, Nancy Morrison gave something like 60 times the usual dose of morphine to a patient, and, when she thought that was not working, she injected him with potassium chloride in exactly the same way as Dr Cox. The patient was a very large man and he was opiate resistant. The judges said, "There is no reason for pursuing this".

These contradictory results give patients, doctors and the community no guidance on how to act and what to expect.

**Solution - legislation**

One way to fix the contradictory legal treatment of terminal palliation is simply to remove ourselves from the 'double-effect' language altogether and to set up a statutory scheme providing protection for good medical practice in this area. This is the preferable way to go. Such a legislative approach has been adopted in South Australia, Western Australia and Queensland.

In South Australia, section 17 of the Consent to Medical Treatment and Palliative Care Act 1995 (SA) provides:

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

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

(b) in good faith and without negligence; and

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

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

That is what is needed. We do not need to go through 'double-effect'. Intention and causation do not need to be talked about. It can simply be resolved by saying, "Did you do this with the consent of the patient or their relatives? Was it done well and was it done according to good medical practice?"

**Solution - defences**

The other way, if the parliament does not act, and will not legislate, is to have a new defence in law. Rather than fiddle with intention and causation, could there be a defence in circumstances of socially justifiable behaviour which can be excused? If so, what defence can be used?

**Consent**

One could seek to rely on the defence of consent. Helping people die with minimised pain and suffering is in the public interest. Surely a defence of consent can arise there. In fact, it has arisen recently in the Supreme Court of Montana.

Consent is not going to help in all jurisdictions. The ACT and the Northern Territory do not actually give relatives the power to consent for their incompetent adult. Therefore, in the ACT and Northern Territory, a defence of consent will work only when the patient is a competent adult, and that might be difficult in many situations, particularly in intensive care where people are usually unconscious.

**Necessity**

The other potential defence is necessity. Necessity is applied in many situations, medical emergencies or abortion. Normally, the avoidance of an irreparable evil is looked for, the fact that there is no reasonable alternative. The acts have to be reasonably proportionate to the evil avoided.

In fact, that is almost a perfect match for 'double-effect'. So why is 'double-effect' not simply shifted from causation and intention where it sits now and put it into the area of defences? That seems to be its natural home.

Of course, necessity has not usually been allowed as a defence to murder. It was opened up by the Queensland Supreme Court about ten years ago in a case concerning conjoined twins, where it was held that one could use necessity as a defence to murder in some situations. In that case they had to kill one of the twins to save the other. The Supreme Court of Canada has also recognised that necessity is available as a defence to murder.

**Benefits of the defence approach**

The benefits of the defence approach are:

1. the doctrinal integrity of the legal approach to intention and causation is left intact. Admit that there is an intention and there is a causation, then consider whether the action was justifiable. In effect, that is what the House of Lords was doing in Bland, by looking at who was doing it and why they were doing it.
2. a normative issue is not being disguised. It is actually being examined. This encourages discussion about death management, whereas at the moment the current law pushes it under the carpet. This should create a space for the discussion, as a society, of what is proper palliative care or proper intensive care withdrawal or proper sedation in different contexts.
3. greater certainty for patients, practitioners and society.

**Costs of the defence approach**

The cost of moving away from inconsistent intention and causation approaches towards defences such as justifiable behaviour are:

1. the ideological divider is gone and doctors would have to admit that sometimes, in some situations, they are causing the patient's death. That is not purely rhetorical. It is an important psychological issue for doctors.
2. there is the danger of the slippery slope. If we start to say that we do kill, then other people might say, "It was proportionate for me to use potassium chloride because nothing else was working". Dr Nancy Morrison would have said that. Dr Nigel Cox would have said it. Would the judges have accepted it?

**Puzzle**

Dr Harold Shipman killed over 400 people with opiates. He would deliberately overdose them on opiates. Certainly, Shipman is one of the worst serial killers ever known. Then there is another doctor, Dr David Moor. Dr David Moor used opiates on a patient and terminally palliated that patient.

Arguably, he should have actually got some help, but he was someone who was at least caring for his patient and trying to help his patient.

So what is the difference between those two? Intention? Causation? That one is a nice person and one is not? Can a legal system distinguish between them?

The laws themselves cannot distinguish. The system is distinguishing by inconsistent manipulation of the laws, using reasons outside the law itself. But it is not distinguishing by properly applying the actual law. The law is not working. If one considers it on intentional grounds, Harold Shipman had an intention to kill. He is a serial killer. He is a madman. He desired to kill. But David Moor would also be found to have an intention to kill, either because he knew that he was accelerating death or because he knew that there was a probability that his actions would cause death.

In terms of causation, one cannot argue omission here. They are not available. If one is injecting a patient with drugs and they die because of an overdose of drugs, it is not an omission.

What were they both doing? They were both overdosing their patients with drugs. So causation does not distinguish them either.

Is it about the type of drugs, because that seemed to be important in Cox? No, it is not, because they are both using the same drugs. So is it really about whether we like one of them and we do not like the other one? A legal system should not operate that way. It is easy to fix, but it requires some parliamentary bravery, or a novel defence to murder.

**Conclusion**

Our legal system should encourage the best care possible for people who are dying. At the moment, it is not doing that, and we need to do something to fix it. We need to stop destroying the law to reach outcomes we find desirable. We should move away from intention (which is being used inconsistently) and causation (which says nothing about moral quality) and towards defences (such as justifiable behaviour). Such an approach involves an honest acceptance of the intentional acceleration of death, but still leaves room for the debate about proportionality of action.