CARE OF TERMINALLY-ILL PATIENTS BILL 2002

EXPLANATORY NOTES

GENERAL OUTLINE

Objectives of the legislation

To clarify the obligations of doctors treating terminally-ill patients, and to ensure that doctors and nursing staff who administer drugs to such patients for the purpose of pain relief are not held under threat of prosecution because an incidental effect of the treatment is to shorten the life of the patient.

Reasons for the objectives and how they will be achieved

There is a grey area in the law of Queensland at the moment, where medical practices that are acceptable at common law and acceptable under the moral philosophy of most churches (in particular the Catholic Church) are possibly in breach of the Criminal Code. This area relates to the palliative care of people who are dying in great pain. Sometimes the pain can only be relieved by such large doses of opioids that the patient s breathing is depressed, and obviously at this stage there is a danger that the breathing will stop. Therefore a doctor who is concerned to relieve the patient s pain must prescribe pain relief in such doses that it is possible that it will shorten the patient s life by some hours, or days, or weeks. A question then arises as to whether the doctor is to be regarded as having intentionally killed the patient.

Under the common law and in the moral philosophy of at least the Catholic Church, and possibly other Churches, the answer to this

question is no . In *R v Adams* [1957] Crim LR 365, Lord Devlin directed the jury that a doctor is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes *incidentally* shorten life . This is in accordance with the *doctrine of double effect* in moral philosophy. This is a doctrine of Catholic origin, to which non-Catholic philosophers are now paying more attention as well, that states that an action that has both a good effect and a bad effect is permissible if it is not wrong in itself and if the evil result is not directly intended.

However, the situation in Queensland is not so clear. Section 296 of the *Criminal Code* provides that

> A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person.

This section makes no reference to the intention of the person — therefore it seems that a doctor whose prescription of medicine hastens the death of a patient, even by seconds, is technically guilty of, at least, manslaughter, regardless of concern for the best interests of the patient, lack of intention to kill, lack of foreseeability, compliance with best medical practice, or any other factor.

This Bill is intended to remove the threat of prosecution from doctors, and staff working under their direction, in the circumstances listed in the next sentence. It does this by clearly spelling out, in clauses 2 and 3, that where a doctor has prescribed pain-killing medication with the intention only of relieving pain, with the proper consents, in good faith, without negligence and in accordance with best practice, but the medication also has the effect of shortening the patient s life, neither the doctor nor the staff under the doctor s supervision incur any civil or criminal liability. It further provides that the administration of medication under these conditions does not constitute an intervening cause of death; this will be relevant when

there are accusations that some earlier actions of a person or persons has caused the death of the patient.

Estimated costs for implementation

This Bill will cause no expenditure of money by the government.

Consultation

Consultation has occurred with:

- various doctors, nurses, ministers of religion, palliative-care workers, people with terminal illnesses and relatives of people who have died in pain or who have terminal illnesses, in the electorate of Nicklin;
- The Catholic Archbishop of Brisbane and his advisor on bioethical matters;
- The Queensland Branch of the Australian Medical Association;
- The Sunshine Coast Euthanasia Association, the Right to Life Association Queensland and the Palliative Care Association of Queensland;
- Pro-Life South Australia and the Palliative Care Council of South Australia, as to how a similar Act in South Australia has worked in practice.

Consistency with fundamental legislative principles

The Bill is consistent with fundamental legislative principles. Although the sometimes-competing rights or desires of patients — first to continue living and, secondly, to avoid excessive pain — are not encompassed by the rights and liberties of individuals listed in

section 4 of the *Legislative Standards Act 1992*, it is appropriate to comment on this matter here. The Bill attempts to strike a balance between these two rights in a way that is consistent with both the common law and religious doctrine.

As to the rights of those treating terminally-ill patients, it is arguable that the existing law has insufficient regard to the fundamental principle in section 4(3)(a) of the above Act, that rights and liberties should not be excessively dependent on administrative power (ie, in this case, the discretion of the prosecuting authorities). The Bill is an attempt to remedy that deficiency.

NOTES ON CLAUSES

The Bill is adapted from the *Consent to Medical Treatment and Palliative Care Act 1995* (South Australia), sections 17 and 18.

Clause 1 sets out the short title of the Act.

Clause 2 specifies the persons who may give consent to palliative treatment which may run a risk of shortening the life of the patient. Where the patient has capacity to make decisions about health matters (a term used in both the Guardianship and Administration Act 2000 and the Powers of Attorney Act 1996), the patient must give consent. Where the patient has impaired capacity, the clause refers to the provisions of section 66 of the *Guardianship and Administration Act 2000,* which provides:

Adult with impaired capacity order of priority in dealing with health matter
66 (1) If an adult has impaired capacity for a health matter, the matter may only be dealt with under the first of the following subsections to apply.

(2) If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.

(3) If subsection (2) does not apply and the tribunal has appointed 1 or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order.

(4) If subsections (2) and (3) do not apply and the adult has made 1 or more enduring documents appointing 1 or more attorneys for the matter, the matter may only be dealt with by the attorney or attorneys for the matter appointed by the most recent enduring document.

(5) If subsections (2) to (4) do not apply, the matter may only be dealt with by the statutory health attorney.

The statutory health attorney just referred to is defined by s 62 of the *Powers of Attorney Act 1996*:

Who is the statutory health attorney
63.(1) For a health matter, an adult s **statutory health attorney** is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter
(a) a spouse 66 of the adult if the relationship between the adult and the spouse is close and continuing;
(b) a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult;
(c) a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.
(2) If no-one listed in subsection (1) is readily available and culturally appropriate to exercise power for a matter, the adult guardian is the adult s **statutory health attorney** for the matter.
(3) Without limiting who is a **person who has the care of the adult** , for this section, a person has the care of an adult if the person
(a) provides domestic services and support to the adult; or
(b) arranges for the adult to be provided with domestic services and support.
(4) If an adult resides in an institution (for example, a hospital, nursing home, group home, boarding-house or hostel) at which the adult is cared for by another person, the adult
(a) is not, merely because of this fact, to be regarded as being in the care of the other person; and
(b) remains in the care of the person in whose care the adult was immediately before residing in the institution.

If there is a disagreement about which of 2 or more eligible people should be the statutory health attorney or how the power should be exercised, one has to turn back to the *Guardianship and Administration Act 200*0, of which section 42 (Disagreement about health matter) applies.

Clause 3 provides that where the listed conditions are complied with, neither a medical practitioner nor persons working under the practitioner s direction are subject to any civil or criminal liability should the patient s life be shortened, and provides specifically that section 296 of the *Criminal Code* does not apply. The listed conditions are that:—

- the treatment is administered with the sole intention of relieving pain;
- the parties have acted in good faith and without negligence;
- the consent required under clause 2 has been obtained; and
- the treatment is in accordance with proper professional standards of health care.

It is anticipated that the proper professional standards will change from time to time as new medical treatments are available; this section will place an onus on doctors contemplating the administration of drugs in dangerous doses to keep up to date with developments in palliative care.

Clause 4 provides that treatment administered in accordance with clause 3 does not constitute an intervening cause of death. This may be relevant in prosecutions for murder or manslaughter, or in related civil actions, where an earlier action of some person is alleged to have caused the patient s death. The clause will ensure that the accused person cannot argue that in fact the death was caused by the medical treatment.

Clause 5 is included purely for the avoidance of doubt. It is considered that the text of clauses 2 and 3 makes it absolutely clear that this Bill does not authorise the administration of drugs where the intention is the death of the patient rather than the relief of the patient s pain, but this clause is added to make that intention, if possible, even more clear.