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Inquiry into
Palliative Care in Australia

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Introduction

We are academics in the Health Law Research Program at the QUT Faculty of Law whose research over the past decade has focused almost exclusively on end of life decision-making. We are currently undertaking two major studies funded by the Australian Research Council that are relevant to this inquiry. The first looks at the role that law plays in decisions to withhold and withdraw life-sustaining treatment from adults who lack capacity and the second looks at why futile treatment (a contested concept) is provided at the end of life rather than a focus on palliative care. We make this submission in our role as academics drawing on this background. Our submission considers four issues that we consider are significant for this inquiry from a legal and policy perspective:

- Key values for law in this area
- The importance of advance care planning
- Avoiding futile treatment
- Ensuring that law supports the provision of appropriate palliative care

Key values for law in this area

Before turning to more specific issues that arise from the Inquiry's terms of reference, we identify what we consider to be the key values for law in this area, including that which governs advance care planning and substitute decision-making. We consider there is merit in expressly identifying the values that should underpin the law in this area to inform decision-making about future legal regulation. We believe that there is general consensus that the below list of values are relevant to decisions in this area. There may, of course, be different views as to the relative importance of these values and how they should be translated or reflected in law.

- Autonomy or self-determination – a person should be able to make choices about their life, including whether or not they would accept aggressive treatment to prolong their life.
- Sanctity of life – human life is important and the State has a role in protecting the lives of its citizens.
- Dignity – this can mean a range of things but of significance in this context are questions about a person's dignity if he or she is being kept alive artificially through burdensome treatment.
- Equality – decision-making about health care (including access to health care) should not be discriminatory. One application of equality is ensuring that people with disabilities have the same rights to health care as anyone else. Assessments of a person's quality of life in making end of life decisions can also give rise to issues of equality.
- High quality decision-making by the person receiving care, his or her substitute decision-maker (if relevant) and health professionals – decisions involving medical treatment at the end of life are very important. The law should establish a framework that promotes high quality decision-making by all those involved.
- Clear, accessible, consistent law – these values are important for this area of law as it is intended to be used by the community without regular recourse to legal advice or the

courts or tribunals. The law should be such so that members of the community and health professionals are capable of knowing and complying with their legal rights and responsibilities.

- Fair, transparent, efficient dispute resolution – where disputes arise, as they sometimes will, the law needs to establish a framework for resolving those disputes in accordance with these values.

One observation we make at this point is to note the conflict that can sometimes arise between a person’s right to self-determination and the State’s interest in the sanctity of life. When considering how these conflicting principles should be resolved, the courts have uniformly concluded that self-determination should prevail over the sanctity of life. In the landmark decision of *Airedale NHS Trust v Bland*, Lord Goff stated:¹

First, it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so ... To this extent, the principle of the sanctity of human life must yield to the principle of self-determination ... Moreover the same principle applies where the patient’s refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it ...

Recent Australian case law – *Brightwater Care Group (Inc) v Rossiter*² and *Hunter and New England Area Health Service v A*³ – has confirmed this is also the approach taken in this country. We support this approach: see L Willmott, B White, B Mathews, ‘Law, Autonomy and Advance Directives’ (2010) 18 *Journal of Law and Medicine* 366.

The importance of advance care planning

There is strong support from the community and health professionals for advance care planning and the contribution it can make to achieving a good death. This can be seen from the range of calls in recent years for greater support of advance care planning. Examples of this can be found the Productivity Commission’s report *Caring for Older Australians*,⁴ the National Health and Hospitals Reform Commission’s *A healthier future for all Australians*⁵ and the report *Older People and the Law* by another Committee of the Commonwealth

¹ [1993] AC 789, 864. These comments were referred to in *Re AK (Medical Treatment: Consent)* [2001] FLR 129, 133-134 (Hughes J) and *HE v A Hospital NHS Trust* [2003] 2 FLR 408, 416 (Munby J). See also *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Donaldson J).

² [2009] WASC 229.

³ (2009) 74 NSWLR 88.

⁴ Productivity Commission, *Caring for Older Australians* (2011), eg Recommendation 10.4 which states that ‘Providers of aged care services should have staff trained to be able to discuss and put in place advance care directives’.

⁵ National Health and Hospitals Reform Commission, *A healthier future for all Australians* (2009), eg Recommendations 51 and 57.

Parliament.⁶ Part of the impetus for greater emphasis on advance care planning and advance directives has come from the community with some individuals wanting to have greater control over their future medical care. But it has also been prompted by health professionals who are increasingly concerned about seeing people die when they are still receiving burdensome treatment that they are unlikely to have wanted.

Effective advance care planning requires appropriate support (at least) across the domains of:

- Law
- Policy
- Education

Law

It is critical to have a strong, clear and effective legal framework to support advance care planning. Generally such a framework will have two components: it will provide for the completion of an advance directive (AD), and it will facilitate for a substitute decision-maker (SDM) to make health care decisions on behalf of a person if and when decision-making capacity is lost. An AD is part of a wider process of advance care planning and is a legally binding document or statement where a competent individual decides what treatment he or she would accept or refuse at a future time when they lack capacity. Allowing a person to give directions in advance promotes autonomy and, because this sets out treatment choices, can provide that person with dignity in the dying process. If an AD has not been completed and a decision is made by a SDM which reflects the views and wishes of the patient, that person's autonomy and dignity is similarly promoted.

Need for national consistency: There has been consistent and broad based support for national consistency of law governing the legal framework at the end of life, particularly as it relates to advance care planning.⁷ We add our support to the many and repeated calls for a national approach to this area. We also endorse the recent efforts of Australian Health Ministers Advisory Council (AHMAC) to better harmonise laws in this area in their recent Report, *A National Framework for Advance Care Directives*. Ongoing consideration will be needed as to how the move towards national harmonisation is best achieved. For example, we note our reservations about the use of the term 'advance care directives' in that report as an umbrella term referring to both documents that give directions about future medical treatment and documents that appoint a SDM. Terminology matters in this field as evidenced by confusion in the various jurisdictions arising from the different terms used for the same concept. We anticipate similar confusion arising from the use of the term 'advance care directives' to include documents that appoint a SDM as this is not consistent with the terminology generally used in Australia.

⁶ Commonwealth Parliament, House of Representatives, Standing Committee on Legal and Constitutional Affairs, *Older People and the Law* (2007), eg Recommendations 24 and 27.

⁷ See for example, Commonwealth Parliament, House of Representatives, Standing Committee on Legal and Constitutional Affairs, *Older People and the Law* (2007), eg Recommendations 25, 26, and 28; Productivity Commission, *Caring for Older Australians*, 2011, eg Recommendation 15.10.

Need for effective decision-making: A legal framework needs to facilitate effective decision-making in all circumstances that arise at the end of life in accordance with the values outlined above. Putting aside problems associated with national inconsistency, there are also aspects of the law in this area that do not function effectively within individual Australian jurisdictions.

There have been a number of reviews at State level that have identified a range of problems with the law in this area and urged reform. They include:

- Queensland – B White and L Willmott, *Rethinking Life-Sustaining Measures* (2005), and Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws*, Report No 67 (2010)
- New South Wales – New South Wales Parliament, Legislative Council, Standing Committee on Social Issues, *Substitute Decision-Making for People Lacking Capacity* (2010)
- Victoria - Victorian Law Reform Commission, *Guardianship*, Consultation Paper 10 (2011) (the final report has been completed but is not yet publicly available)
- South Australia – South Australian Advance Directives Review Committee, *Advance Directives Review — Planning Ahead: Your Health, Your Money, Your Life*.

Improving this area of law, so that it may support and encourage effective decision-making at the end of life (including advance care planning), is an important priority for the responsible governments. We understand that these issues are regulated at State level but they are of significance for this inquiry as problems with the legal framework have an impact upon how care at the end of life is provided, including the transition to palliative care. We consider that not only should there be efforts supported at a federal level to harmonise this area of law, but also to improve it.

One simple illustration of the sorts of problems that can arise and impede good decision-making at the end of life is the distinction drawn in Victoria and New South Wales where, in some cases, a SDM is empowered to *withhold consent to treatment* but they are not able to *refuse treatment*. This is a fine legal distinction, but one with potentially significant results in that a SDM may not be legally authorised to insist that some aggressive forms of treatment cease, and palliative care be provided. We favour removing this distinction between withholding consent to treatment and refusing treatment. We would also grant all SDMs (including the default decision-maker under these regimes, often called the ‘person responsible’) the power to refuse treatment in accordance with the relevant criteria and safeguards set out in the legislation.⁸

⁸ In relation to Victoria for example, this argument is outlined further in L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)’ (2011) 18 *Journal of Law and Medicine* 773, p790. For some of the problems that arise with this distinction, see pp781-782 and 785-786. In relation to New South Wales, see B White, L Willmott, P Trowse, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 1 (New South Wales)’ (2011) 18 *Journal of Law and Medicine* 497.

Current legal frameworks are unnecessarily complex: Part of improving the relevant legal frameworks involves avoiding unnecessary complexity. In a series of three articles published in the *Journal of Law and Medicine*, we have reviewed the law in this area in three jurisdictions – Victoria, New South Wales and Queensland.⁹ This series observes that the applicable law will depend on a range of factors including in which jurisdiction it occurs, whether the patient has capacity or lacks capacity, whether or not treatment is provided in an emergency context, and whether the patient has made an AD, or appointed a SDM. This series of articles also observes that the law in this area (and particularly in relation to life-sustaining treatment) is uncertain, inconsistent, makes distinctions that are counterintuitive or unnecessarily fine, and is generally complex.¹⁰

A simple example of the complexity is that the relevant law is sometimes spread over a number of statutes. For example, this is the case in the Australian Capital Territory, Victoria, South Australia and Queensland. We favour a single guardianship statute.

Another example is how ‘capacity’ is defined in different legislative contexts. Again, by way of illustration, we note that in Victoria there are four different approaches or tests for capacity across the *Guardianship and Administration Act 1986* (Vic) and *Medical Treatment Act 1988* (Vic):¹¹

- Part 4A of the *Guardianship and Administration Act 1986* (Vic) approaches capacity based on the general nature and effect of a decision and an ability to communicate that decision.
- Under the *Medical Treatment Act 1988* (Vic), a person must be of ‘sound mind’ to be able to complete a refusal of treatment certificate.¹²
- Under the *Medical Treatment Act 1988* (Vic), if an adult ‘becomes incompetent’, then the agent is able to complete a refusal of treatment certificate.¹³
- Finally, for a guardian to be appointed by VCAT¹⁴ or for an enduring guardian’s power to commence,¹⁵ the adult must have a disability and be ‘unable by reason of

⁹ B White, L Willmott, P Trowse, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 1 (New South Wales)’ (2011) 18 *Journal of Law and Medicine* 497; L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 2 (Queensland)’ (2011) 18 *Journal of Law and Medicine* 522; L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)’ (2011) 18 *Journal of Law and Medicine* 773.

¹⁰ L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)’ (2011) 18 *Journal of Law and Medicine* 773 generally, but particularly at pp791-793.

¹¹ L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)’ (2011) 18 *Journal of Law and Medicine* 773, pp775-776.

¹² *Medical Treatment Act 1988* (Vic), s 5(1)(d).

¹³ *Medical Treatment Act 1988* (Vic), s 5A(2)(b).

¹⁴ *Guardianship and Administration Act 1986* (Vic), s 22(1).

¹⁵ *Guardianship and Administration Act 1986* (Vic), s 35B(1)-(2).

[the/a] disability to make reasonable judgments’ in relation to the decisions that need to be made.

It is obviously undesirable to have different terms and approaches to capacity (or any other issue), even if in practice it may be that they are interpreted in the same way. This is particularly important given the need for community to understand these laws. We have argued that the state of the law in this regard is an impediment to medical professionals’ understanding of this aspect of the law¹⁶ and we would expect that other parts of the community would struggle as well. When law is in this state it is contrary to the value outlined above that law should be ‘clear, accessible, consistent’.

Policy

The importance of policy: Although an appropriate legal framework is necessary to support good decision-making, it is not sufficient to achieve that goal. There also needs to be effective and funded policy to translate law into practice, to create environments in which good practice can occur, and to support advance care planning generally. We are aware that much work has been done in this regard in New South Wales and Queensland. This was triggered in Queensland by a coronial inquest in 2009 where the State Coroner recommended that hospital policies be reviewed to ensure that medical practice complied with certain legal requirements.¹⁷ In response to this decision, Queensland Health has undertaken considerable work in developing forms and policies, underpinned by extensive tools and staff training to promote appropriate decision-making, including advance care planning. However, more needs to be done for good practice to occur consistently across the health and aged health care sectors.

Palliative Care Australia Standards: We note the inquiry’s terms of reference specifically include examining Palliative Care Australia’s *Standards for Providing Quality Palliative Care for all Australians*. This is an important document that seeks to enhance the provision of palliative care nationally, both within the specialist palliative care setting and beyond. We note that this document already refers to ‘decision-making’ and ‘care planning’, and that it considers the application of the Standards to individuals who have lost decision-making capacity. We also note that it could be argued that aspects of advance care planning are already embedded in some of the Standards in that they promote conversations about treatment choices and other decision-making. However, we consider that there is greater opportunity to explicitly promote the role of advance care planning as an integral part of good palliative care:

- For example, we suggest consideration be given to including references, where appropriate in the relevant context, to ‘advance care planning’ rather than just ‘care planning’.

¹⁶ L Willmott, B White, M Parker, C Cartwright, ‘The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)’ (2011) 18 *Journal of Law and Medicine* 773, pp792-793.

¹⁷ Barnes M, State Coroner. Inquest into the death of June Woo (COR 2713/02). Brisbane: Queensland Coroner’s Court, 1 Jun 2009.

- It would also be desirable to include some discussion of advance care planning in the ‘intent’ or ‘criteria’ sections of the document.

The rationale for these suggestions is two-fold. First, advance care planning is a concept which is widely understood in the health professions and we consider that the use of this term conveys a wider notion than just ‘care planning’. For example, we would argue it implies at least some level of formality and documentation which might not be captured by ‘care planning’. The latter term might also be seen as more clinically oriented than advance care planning which has historically been patient-centred. We are aware of the strong focus of palliative care as a speciality on being patient-centred but note that the intended use of the Standards beyond the specialist palliative care setting.

Secondly, the inclusion of the word ‘advance’ matters because it makes clear the importance of the timing of these discussions. One of the impediments to transitioning to palliative care at an appropriate time, is that conversations about issues such as prognosis, likely quality of life and the nature of possible medical treatment occur too late. We consider making explicit the importance of early discussions, in advance of when decisions are needed, would improve outcomes for patients.

Observations on other policy support for advance care planning: We also note our support for a range of other policy initiatives that will promote advance care planning:

- Including advance care planning in the Medicare Benefits Schedule so that health professionals are encouraged and remunerated to provide this service.¹⁸ With colleagues, we undertook a small survey of doctors who identified a number of reasons why this is appropriate: ‘it requires considerable medical knowledge, is time consuming, is part of complex decision making, forms part of medical management of a patient, requires regular review and sometimes collateral discussion with relatives.’¹⁹
- Using electronic health records to notify medical and other health professionals of any advance care planning that has occurred. This planning (which represents the wishes of the patient) needs to be prominent so it is easily found in the clinical environment.
- Ensuring that on admission to hospitals or residential facilities, individuals are asked about whether any advance care planning has occurred, and whether an AD has been completed or a SDM appointed. There needs to be an increased emphasis on ensuring that these decisions are brought to the attention of those who are providing health care to the adult. We therefore endorse the proposal of the Queensland Law Reform Commission to impose obligations on those in charge of hospitals, residential aged care facilities and residential disability services to make inquiries as to whether an adult has an AD (or an enduring power of attorney for health matters).²⁰ We note that

¹⁸ See also Commonwealth Parliament, House of Representatives, Standing Committee on Legal and Constitutional Affairs, *Older People and the Law* (2007), Recommendation 23.

¹⁹ C Tilse, J Wilson, A-L McCawley, L Willmott, B White, *Enduring documents: Improving the forms, improving the outcomes* (2011), p114, available at: http://eprints.qut.edu.au/46893/1/Enduring_documents_-_improving_the_forms%2C_improving_the_outcomes.pdf.

²⁰ Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws*, Report No 67 (2010), Vol 2, pp56-59.

these recommendations are reflective of the legal position that already exists in some other jurisdictions such as the Australian Capital Territory.

Education

We consider that there needs to be widespread education strategies about the nature, purpose and legal implications of advance care planning. Such education is required at two levels: community and families, and medical and other health professionals.

Community and families: Individuals will not appoint SDMs or complete ADs, or have discussions with their families about their preferences for treatment at the end of life if they are unaware of their right to do so, and the implications that flow from such actions. These kind of discussions may be challenging, but they need to occur, and steps should be taken to utilise opportunities and networks to facilitate them occurring. For example, literature and hard copies of ADs could be available at no cost in a range of locations including doctors' surgeries, community health service centres, employment centres, community legal centres, Indigenous legal services and government offices generally.²¹ Lawyers, when approached to draft wills and enduring powers of attorney, could also encourage their clients to complete ADs, and to have conversations with their family about their preferences for end of life medical treatment.²² Again, work already undertaken by NSW Health and Queensland Health directed at community education are useful steps forward.

Medical and health professionals: It is important for medical and other health professionals to understand how advance care planning operates, and how to have discussions with patients about planning options. There is only very limited empirical evidence about the medical and health professionals' legal knowledge of advance care planning. In the series of the three articles mentioned above, we reviewed that evidence which was available and concluded that it indicated some knowledge gaps.²³

It is important to ensure that strategies for undertaking end of life discussions are included as part of medical education, as well as the subject of ongoing dialogues about professional responsibilities. We also note the integral role that health professionals other than doctors play in advance care planning and the importance of supporting them to undertake this role. For example, we note the recommendations of the Productivity Commission that '[p]roviders

²¹ C Tilse, J Wilson, A-L McCawley, L Willmott, B White, *Enduring documents: Improving the forms, improving the outcomes* (2011), p122, available at: http://eprints.qut.edu.au/46893/1/Enduring_documents_-_improving_the_forms%2C_improving_the_outcomes.pdf.

²² C Tilse, J Wilson, A-L McCawley, L Willmott, B White, *Enduring documents: Improving the forms, improving the outcomes* (2011), p122, available at: http://eprints.qut.edu.au/46893/1/Enduring_documents_-_improving_the_forms%2C_improving_the_outcomes.pdf.

²³ B White, L Willmott, P Trowse, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 1 (New South Wales)' (2011) 18 *Journal of Law and Medicine* 497, pp518-521; L Willmott, B White, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 2 (Queensland)' (2011) 18 *Journal of Law and Medicine* 522, pp540-542; L Willmott, B White, M Parker, C Cartwright, 'The legal role of medical professionals in decisions to withhold or withdraw life-sustaining treatment: Part 3 (Victoria)' (2011) 18 *Journal of Law and Medicine* 773, pp788-790.

of aged care services should have staff trained to be able to discuss and put in place advance care directives'.²⁴

Avoiding 'futile treatment'

We wish to address the issue of providing treatment at the end of life where, in the eyes of the patient, the burdens of that treatment outweigh the benefits, and where it is physiologically impossible for treatment to achieve the desired outcome (for example, providing antibiotics which cannot cure a viral infection). The issue of providing treatment that is seen as futile is becoming increasingly significant in public, professional and policy debates about treatment at the end of life.

Meaning of futility: At the outset, we note that although a number of different definitions have been advanced in the literature, there is not a consensus about the meaning of the term 'futility'. Whether medical treatment will be regarded as futile in a particular context (or whether there should even be such a concept) is often contested. Different people have different understandings of the term, including that treatment will not work, that treatment has a very low chance of success, that treatment will result in a poor quality of life outcome or that the burdens outweigh the benefits of treatment. Despite a lack of consensus about what the term means, it is used frequently by medical and health professionals.

Intersection between futility and resourcing: Whether particular treatment is futile for a particular patient requires an individual assessment of the circumstances of that patient. The factors that must be assessed are the patient's diagnosis and prognosis, as well as factors personal to that patient including their characteristics, views and wishes. This assessment is and must be unrelated to issues of resourcing. That said, it is also true that resourcing of health care is a critical issue that needs to be addressed as part of a broader discussion about what care should and can be provided to individuals at the end of life. In this debate, the authors emphasise the importance of not making assessments about futility which are actually decisions based on financial constraints that exist in the health sector.

Our definition of futility: For the purposes of this submission, we use the term 'futile' to refer to two situations: where the treatment is physiologically futile (that is, the treatment cannot work to achieve the medical outcome it is intended to achieve), or the treatment is that which the patient has indicated he or she does not want to receive as it will not result in a quality of life outcome that is acceptable to the patient. (In a clinical setting, the treating team would be aware of the patient choice if appropriate advance care planning has taken place.)

Futile treatment should not be provided: When 'futility' is defined as outlined above, there is no legal or ethical justification for providing it. Indeed, in some cases such as where the patient has refused treatment, the provision of the treatment will constitute an assault. Provision of treatment in such a case would also breach a medical practitioner's professional and ethical obligations. There are also resourcing implications of such a decision – limited

²⁴ Productivity Commission, *Caring for Older Australians* (2011), Recommendation 10.4.

resources would be used on providing treatment that is either not effective or that the patient does not want to receive. Continuing to provide this sort of treatment can also be inconsistent with an appropriate shift to palliative care.

The efficient use of palliative, health and aged care resources falls squarely within the Committee's terms of reference. The point we make here is that if treatment will not work or is not wanted, resources should not be used to provide it. Yet there is evidence that treatment is being provided in such circumstances for a range of complex reasons. It is therefore critical to ensure that there is the legal and policy framework to support decisions *not* to provide treatment in such cases.

Ensuring that law supports the provision of appropriate palliative care

One potential impediment to effective palliative care continues to be concerns of health professionals about the legal risk of providing palliative care. More detail on the matters we discuss below can be found in an article we wrote with a palliative care specialist called 'Palliative care, double effect and the law in Australia'.²⁵

There is a concern that the provision of medication may contribute to the hastening of the patient's death and could potentially expose the clinician to criminal prosecution. We are aware of the arguments as to why appropriate palliative care need not hasten death but note that this concern nevertheless remains, at least to some extent. As a result of this, there is anecdotal evidence that insufficient palliation is sometimes provided and a patient's pain may not be appropriately managed. Both of these outcomes – health professionals being concerned about potential criminal liability and insufficient pain relief at the end of life – are clearly undesirable.

The common law has responded to the situation by providing a defence where the patient dies, and the medication provided to the patient to alleviate the pain is thought to have contributed to the patient's death. The defence is referred to as the doctrine of double effect. In the context of palliative care, the doctrine can be relied on when the following four conditions are met: administering palliative medication is not, in itself, immoral; the intention is to relieve pain, not to hasten the patient's death; the relief of pain is not achieved through causing the patient's death; and proportionally, the need to relieve pain is such that it warrants accepting the risk of hastening death. Where palliative care is provided in the context of good medical practice with an appropriate intent, these four conditions will clearly be met. Although the legal basis for the doctrine of double effect forming part of Australia's common law is unclear, it is extremely unlikely that a health professional would ever be found criminally liable for a patient's death in these circumstances.

Nevertheless, there is anecdotal evidence that some concerns about criminal responsibility remain. Education of health professionals is essential to reassure them that palliative care

²⁵ B White, L Willmott and M Ashby, 'Palliative care, double effect and the law in Australia' (2011) 41(6) *Internal Medicine Journal* 485.

provided in accordance with good medical practice and an appropriate intent will be lawful so that patients are not deprived of adequate pain relief at the end of life.

Consideration should also be given by State governments as to whether the protection currently provided by the common law should be given legislative force. This is particularly important where the criminal law is regulated by a Criminal Code as in these jurisdictions the status of a common law defence is less clear. This sort of reform can give greater confidence to health professionals who can be reassured by a specific legislative provision. Reform of this type has happened in South Australia,²⁶ Queensland²⁷ and Western Australia²⁸ and there is anecdotal evidence (at least in the first two States which have had their legislation for a longer period) that this reform has been a useful educative tool in this area.

²⁶ *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 17.

²⁷ *Criminal Code (Qld)*, s 282A.

²⁸ *Criminal Code (WA)*, s 259.